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ABSTRACT

This process evaluation of the Child Abuse and Neglect Prevention Project describes the efforts of the project director and 10 regional liaisons to develop a statewide philosophy on prevention and an operational plan for directing resources in Texas toward primary and secondary prevention of child abuse and neglect. A survey was used to gather information about what other states were doing in these areas. A total of 30 states responded. Eight of the states had specified definitions for primary and secondary prevention; three states responded to the survey with policy documents focusing specifically on primary and/or secondary prevention; and 13 states indicated that they had a specific program that emphasizes primary and/or secondary prevention services. Analysis of the survey information identified factors appearing to be significant in establishing a quality prevention program. A literature review discusses research projects carried out to determine the most effective kinds of prevention activities and articles describing a theoretical model or operating program not yet tested. It is anticipated that the literature review will be helpful in the decision making process undertaken by the Department of Human Services to decide the direction of prevention efforts in Texas. The state-of-the-art survey and the review of literature are appended. (RH)

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Annual Report: Innovations in Protective Services

P.L. 93-247 Grant Award #06C23/09

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Child Abuse and Neglect Prevention Project

September 30, 1985

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Office of Programs
Texas Department of Human Services

CHILD ABUSE AND NEGLECT
PREVENTION PROJECT

Annual Report

September 1, 1984, through August 31, 1985

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The views expressed herein are those of the authors and do not necessarily reflect the official position of the Office of Human Development Services of the U.S. Department of Health and Human Services.

September 30, 1985

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GENERAL INTRODUCTION

Innovations in Protective Services is the collective name of seven projects funded by P.L. 93-247 state grant money and conducted by the Texas Department of Human Services (DHS). The seven demonstrations, designed to test ideas for improving services to children in need of protection, are listed below:

- Multidisciplinary Institute for Child Sexual Abuse Intervention and Treatment;
- Project Amistad (Friendship), a Joint Venture between DHS and Family Outreach;
- Family-Centered, Home-Based Intervention for Protective Services Clients;
- Child Protective Services Case Management;
- Child Abuse and Neglect Prevention;
- Advanced Job Skills Training; and
- Automated Performance Tracking and Productivity Improvement.

Overall objectives established for the seven projects are to develop innovative child abuse and neglect programs using volunteers and private agencies; to strengthen the quality of services for child abuse and neglect through competency-based and specialized training programs; and to develop models and program designs for planning and delivering child abuse and neglect services and for allocating resources.

Priorities from DHS's long-range plan for child protective services (CPS) provided the basis for selection of the projects to be demonstrated, and project results will be used in planning improvements in CPS service delivery systems.

The project reported on in this document, Child Abuse and Neglect Prevention, proposed to develop (1) a program concept and a philosophy of prevention and (2) an operational plan for directing resources toward primary and secondary prevention of child abuse and neglect.

Copies of this and other reports on the 93-247 projects can be obtained by writing to Project Support and Utilization Section; Office of Research, Demonstration, and Evaluation; Texas Department of Human Services; P.O. Box 2960 (MC 504-E); Austin, Texas 78769.

ACKNOWLEDGMENTS

The Texas Department of Human Services wishes to acknowledge the contributions of people who participated in the development and implementation of the Child Abuse and Neglect Prevention Project and who contributed to project reports.

Susan Watkins, project director, had major responsibility for directing the day-to-day operations of the project. Diane Scott, program specialist, served as consultant to the project director; Carolyn Jones Massey conducted the review of literature; Elizabeth Love conducted the state-of-the-art survey. Special appreciation is accorded to the regional liaisons--Carol Duncan, Bobbie Forsythe, Donna Garrett, Judy Hay, Wilma Manning, Sandra Martin, Belinda Meier, Bruce McNellie, Betty Rovinski, and Roulene Wagonseller--who developed regional prevention plans and met with community leaders to introduce the prevention concept in dealing with child abuse and neglect problems.

From the Office of Research, Demonstration, and Evaluation (ORDE)--headed by Assistant Commissioner Suzette Ashworth, Ph.D.--efforts were contributed by several members of ORDE's Research and Demonstration Division (which is administered by Kent Gummerman, Ph.D.). Project Developer Barbara K. Richardson prepared the original grant proposal. Project Specialist Lucretia Dennis-Small provided support to project staff, prepared reports to the funding source, gave technical assistance, prepared the process evaluation, and arranged for nationwide dissemination of the annual report. Nicholas Constant and Phyllis Jamar of the Technical Communications Unit contributed to the high quality of project documents.

EXECUTIVE SUMMARY

The annual report for the Child Abuse and Neglect Prevention Project gives a process evaluation of progress toward achievement of the established goal and objectives. The report describes the efforts of the project director and 10 regional liaisons to develop a statewide philosophy on prevention and an operational plan for directing resources in Texas toward primary and secondary prevention of child abuse and neglect.

A survey was one method used to gather information about what other states are doing in the areas of primary and secondary prevention. Thirty states responded to the survey. Eight of the 30 states that responded had specified definitions for primary and secondary prevention; 3 states responded to the survey with policy documents that focused specifically on primary and/or secondary prevention; and 13 states indicated that they have a specific program that emphasizes primary and/or secondary prevention services. Analysis of the survey information identified factors that appear to be significant in establishing a quality prevention program.

The literature review discusses two kinds of activities: research projects that have been carried out to determine the most effective kinds of prevention activities and items that describe theoretical models of prevention or an operating program that has not been tested. It is anticipated that the literature review will be helpful in the decision making process undertaken by the Texas Department of Human Services to decide the direction of prevention efforts in Texas.

Both the state-of-the art survey and the review of literature are appended to this report.

BACKGROUND AND ORIGIN

Historically, families have received support and assistance only after problems of child abuse or neglect were readily apparent and identifiable. In recent years, the need for prevention programs has gained national, state, and local attention. Heightened public awareness of the situations that usually precede abuse and neglect has brought greater interest in and support for preventive programs. Prevention, as defined by the child protective services (CPS) program in the Texas Department of Human Services (DHS), operates on three levels:

- primary prevention--activities that promote the health and well-being of all children;
- secondary prevention--activities that promote the health and well-being of children at risk of becoming abused and neglected; and
- tertiary prevention--activities directed toward eliminating the recurrence of abuse and neglect.

Texas DHS has neither a comprehensive plan nor a program philosophy for statewide prevention services. Limited resources have dictated that priority be given to tertiary prevention; primary and secondary prevention efforts are being carried out by diverse groups throughout the state both in coordination with and independently of DHS. Under these circumstances, no assurance can be made that primary and secondary preventive services are available to CPS clients throughout Texas.

After determining the national state of the art for statewide primary and secondary preventive services for child abuse and neglect, the Child Abuse and Neglect Prevention Project will develop a program concept and philosophy of prevention and an operational plan for directing resources toward primary and secondary prevention of child abuse and neglect. The successful completion of this two-year project will provide DHS with a framework to make decisions about allocation of staff and funds for preventive services at the state and regional levels.

PROJECT OBJECTIVES

To assure that primary and secondary preventive services are available to CPS clients throughout Texas, the Protective Services for Families and Children (PSFC) Branch in DHS's Austin headquarters began the Child Abuse and Neglect Prevention Project. To achieve the project's goal of developing a program philosophy on prevention and an operational plan for directing resources toward primary and secondary prevention, the following objectives were established:

1. to determine the national state of the art for statewide primary and secondary preventive services for child abuse and neglect;
2. to identify existing resources and providers of primary and secondary preventive services for child abuse and neglect in Texas;
3. to evaluate the relative effectiveness of the identified primary and secondary preventive services;
4. to index the identified primary and secondary preventive services by source and cost;
5. to identify existing DHS administrative structures and supports for the delivery of primary and secondary preventive services and the additional structures and supports that would need to be developed;
6. to develop a program design for primary and secondary prevention that describes the basic level of primary and secondary prevention to be provided throughout the state and that recommends allocation of funds; and
7. to determine the need for pilot testing any portion of the program design.

EXISTING PREVENTIVE SERVICES

To provide historical information about prevention in child protective services (CPS) to DHS regions and to CPS programs nationwide, two studies were completed--a state-of-the-art survey (Appendix A) and a literature review (Appendix B). Both studies were completed by contractors chosen by administrators in the Protective Services for Families and Children (PSFC) Branch at DHS headquarters in Austin.

The diversity of DHS regions in population, in geographic area, and in number and type of available resources suggested that each region should be involved in the formulation of the statewide prevention plan.

DHS regional directors (RDs--third-line supervisors) were informed about the project and its objectives at a meeting held in October 1984. To assure field involvement, a subcommittee of three RDs was formed to assist the project manager. They represented the seven other RDs and kept them informed about the project's progress.

The RDs designated an individual from each region to work with the project director in identifying existing resources and providers of primary and secondary preventive services. At their initial meeting on February 13-14, each DHS administrative region was represented by one person who served as liaison between his or her region and the project director. Liaison personnel were oriented about the project's purposes and received information about their responsibilities during the project.

Liaison personnel took the lead in developing prevention plans for CPS in their regions. Each regional prevention plan--

- identified existing preventive services in each region, and described them by types (including targeted population), activities, funding, administration, and staffing;
- identified gaps in services, assessed needs, and assigned priorities;
- determined an action plan (what to do, how to start); and
- identified barriers to achieving goals.

At a subsequent meeting in May, the liaison personnel discussed costs and possible benefits of developing a regional prevention plan and how to involve communities in its implementation. Although it was recognized that initiating prevention programs would require dedication of funds, staff time, and other available resources, liaisons agreed that regional prevention plans could produce the following benefits:

- offer a systematic way to look at prevention needs,
- encourage community development and support,

- raise policy issues,

- develop policy from the bottom up,

- give ideas to groups that want to get involved in prevention activities, and

- help implement the project by gathering information.

Regional directors for CPS identified three areas as targets for initial prevention efforts: schools, hospitals, and corporations. In some regions, committees were formed to address the prevention issue. Other regions are planning prevention strategies and programs with the assistance of CPS and other DHS staff; and in still other regions, volunteer specialists have assisted project liaison personnel in initial prevention efforts.

Effectiveness of Preventive Services

So far, the project has not evaluated the effectiveness of the identified primary and secondary preventive services. The project director anticipates evaluating their effectiveness during the second year of the project.

Source and Cost of Preventive Services

During the first project year, there was not enough time to index identified primary and secondary preventive services by source and cost. The second project year will allow time to achieve this objective.

DHS Administrative Structures

During its second year, the project will identify DHS administrative structures and supports for the delivery of primary and secondary preventive services and the additional structures and supports that would need to be developed.

PROGRAM DESIGN FOR PREVENTIVE SERVICES

After final regional prevention plans are adopted, decisions will be made about providing a basic level of services, and recommendations will be made on allocating funds.

PILOT TESTING THE PROGRAM DESIGN

During the first quarter of the second project year, the project director and PSFC branch administrators will determine the need for pilot testing any portion of the program design. If it is determined that there is a need to pilot test any portion of the program design, the Office of Research, Demonstration, and Evaluation will assist the project director in designing the pilot test.

UTILIZATION AND DISSEMINATION ACTIVITIES

The project director was appointed to the Governor's Juvenile Justice Education Project Special Subcommittee. She and the project manager participated in planning three statewide conferences on prevention of child abuse and neglect. These conferences will be held in three Texas cities--Abilene, San Antonio, and Tyler--in October 1985.

The project director and the regional directors for PSFC discussed the need for a statewide advisory committee. Liaison personnel provided the project director with names of suitable candidates for such a committee. A decision about the formation and composition of the advisory committee will be made during the first quarter of the second project year.

The project director made presentations about the project at the annual "Children Who Wait" conference held in Austin on March 3-5. On June 7 in El Paso, Texas, she made a presentation at the board meeting of the Texas Coalition for the Prevention of Child Abuse.

CONCLUSION

The Child Abuse and Neglect Prevention Project has progressed steadily toward its goal of developing a program philosophy on prevention and an operational plan for directing resources toward primary and secondary prevention. The 10 DHS administrative regions have enthusiastically developed regional prevention plans. A number of regions have set up community-wide committees to participate in identifying service delivery gaps and developing plans for starting some project(s) to fill those gaps.

In its second year the project will develop a program design that describes the basic level of primary and secondary prevention to be provided throughout Texas and that recommends allocation of funds. The regions have recognized the tremendous need for a prevention program and view the project as a definite step in the right direction.

APPENDIX A

State-of-the-Art Survey

NATIONAL SURVEY OF PRIMARY AND SECONDARY PREVENTION SERVICES FOR CHILD ABUSE AND NEGLECT

Introduction

The Texas Department of Human Resources, Protective Services for Families and Children Branch, initiated a two year Child Abuse and Neglect Prevention Project in November, 1984. The purpose of this project is to develop a program philosophy of prevention and an operational plan for directing resources toward primary and secondary prevention of child abuse and neglect.

In the protective services for children program, prevention is broadly defined on three levels:

1. primary prevention - activities that promote the health and well-being of all children

2. secondary prevention - activities that promote the health and well-being of groups of children at risk of becoming abused and neglected

3. tertiary prevention- activities that aim toward eliminating the recurrence of abuse and neglect

As the state agency responsible under Texas statute for the protection of children, DHR has policy material relating to all three levels of prevention. However, limited resources have required the Department to give priority to tertiary prevention. Legislation which has been enacted and which will go into effect in September, 1985, established a Children's Trust Fund and a Council on Child Abuse and Neglect which is responsible for developing a state plan for child abuse and neglect prevention services.

Historically, primary and secondary prevention efforts have been carried out by diverse groups throughout the state both in coordination with and independent of DHR. Because of this diversity, the child protective services staff has not been fully aware of primary and secondary prevention services being provided; the areas in which services were being provided; or the extent of the unmet needs for primary and secondary prevention services throughout the state. Consequently, the child protective services program has not had a comprehensive plan and a program philosophy for statewide prevention. The intention of the Child Abuse and Neglect Prevention Project is to assist in meeting this need.

Survey Method and Explanatory Comments

As one step in developing a program philosophy and comprehensive plan for prevention services in Texas, the decision was made to gather information on what other states are doing in the areas of primary and secondary prevention. To accomplish this, a letter was sent from DHR in December, 1984, to all of the state agencies which provide protective services to children. This letter informed the agencies that Texas is in the process of developing a "program philosophy of prevention and an operational plan for directing resources toward primary and secondary prevention of child abuse and neglect." A request was made for a copy of the agency's "child abuse prevention policy" or, if the agency had not developed a separate prevention policy, a copy of the sections of the "Title IV-B Child Welfare State Plan which address prevention."

A total of thirty states responded to the request for information. Approximately 2,000 pages of material were received. However, much of this material was not useable for the purpose of this survey as it contained a wide range of information which was not specifically related to primary and secondary prevention services. Since the letter of inquiry did not define the levels of prevention, it was apparent that some states have a different working definition for primary or secondary prevention from the one used in this survey and/or some states possibly misunderstood that the focus of the survey was on primary and secondary prevention rather than tertiary.

Because of the diversity of content in the material received, the first step of the survey analysis was to review the material received from each state and to summarize the information on a standard format. This format included (1) Sources of Information, (2) Prevention Policy Issues and, (3) Description of Services. After completion of a standardized summary of information for each state, all of the summaries were reviewed to provide the analysis for this national survey.

Throughout the individual state reports, the definitions for primary and secondary prevention services are the ones given in the survey introduction. One area of possible confusion in these definitions was where to include training activities for professionals, community persons, etc. A decision was made to include all of these under primary prevention as they seemed to be more nearly a public relations and education service than a services directly to an identified client group. So even if the training for professionals was in identifying abuse and neglect or in helping high risk families, it was considered as an educational function of primary prevention. If the state had its own definitions for the levels of prevention services, these were given in the "Prevention Policy Issues" section for the purpose of comparison to the survey definitions.

Another possible area of confusion in the individual state reports is the accuracy of the information summarized. The "Sources of Information" are listed for each state in order to clarify just what information was received in making the report. It is probable that some state agencies provide some primary and/or secondary prevention services which are not listed in the individual state report because there was not pertinent information received. Also, the content of the state reports is based strictly on reporting from written material and does not reflect any review or correction by the state agencies. This means there is a reasonable margin for error in specific details. The state reports can best be understood by considering the information in light of the exploratory approach which was utilized for the survey.

Finally, when preparing the state reports from the information received, it was necessary to make some interpretation of what was meant by the description of a service. A particularly tricky term to interpret was "at risk" families and children. This could mean the children are at risk of becoming abused and neglected for the first time or at risk of becoming abused and neglected on a recurring basis. In the absence of a specific statement as to which situation was being identified, services that were described for "at risk" families or children were given the most inclusive meaning and shown as secondary prevention services with the explanatory comment that these services were more than likely a combination of secondary and tertiary prevention.

Summary of Findings

Defining Prevention Services: Eight states of the thirty which responded to the survey have specified definitions for primary and/or secondary prevention. Hawaii, Ohio and Utah define both primary and secondary prevention in terms basically similar to the survey definitions. Oregon, Vermont and Wisconsin include services that are defined in the survey as both primary and secondary prevention under the one heading of primary prevention. Virginia also lumps the two levels of prevention under one definition which is called "preventive protective services." The state of Florida has a prevention plan which includes statements from all eleven districts and each of these districts has its own definition for prevention services. Most of them are similar to the survey definitions; however, there is a definite inconsistency of definitions between different districts.

Prevention Policies: Only three states responded to the survey with a policy document that focuses specifically on primary and/or secondary prevention. California has a "Report to the Legislature, Office of Child Abuse Prevention" which was first submitted on 1-1-82 and is required by state law to be submitted every two years. Florida's "State Plan, A Comprehensive Approach for the Prevention of Child Abuse and Neglect in Florida" was initially prepared 1-1-83 as a result of legislative action. It will be an ongoing report which is synchronized with Florida's budgeting cycle. Vermont responded to the survey with a July, 1984, copy of their "State Primary Prevention Plan."

Hawaii currently speaks to secondary prevention services in their Title XX Plan but a "Child Abuse and Neglect Secondary Prevention Plan" is in the process of development. The state of Ohio is also developing a formalized prevention policy document. Utah prepared a proposal for legislative funding of a "Department of Social Services Child Abuse Prevention Plan" in December, 1984, which outlines a comprehensive child abuse program to concentrate on primary and secondary prevention. Alaska, this year, has submitted a request through the Governor's office to formalize their prevention program by requesting legislation which addresses this issue. Seven states do not apparently have a primary and/or secondary prevention policy. The remainder of the states included their primary and/or secondary prevention policy within a document generally focused on social services; two states supplied their Title XX state plan, four states had handbook material and ten states had their primary and secondary prevention services as a part of their Title IVB state plan.

Delivery of Primary and/or Secondary Prevention Services: The individual state reports include a detailed listing of the primary and/or secondary services which are currently being provided. Seven states furnished material which did not include any description of services that met the survey definitions of primary and/or secondary prevention: Georgia, Kentucky, Montana, Nevada, Pennsylvania, South Dakota and Utah. All of these states have services to prevent child placement but according to the information received these would all be defined as tertiary prevention. Ten states apparently provide some primary and/or secondary prevention services as a regular part of their child welfare system: Maine, Maryland, Minnesota, Mississippi, Nebraska, New Jersey, Oklahoma, Oregon, Rhode Island, and Tennessee.

Thirteen states have a specific program which emphasizes primary and/or secondary prevention services. Alaska has the "Preventive and Early Intervention Youth Services Grant" program which provides contracts with municipal and private mental health providers. Arizona has a specifically defined "Priority 4" classification for secondary prevention services; these cases are transferred to a special unit for case management and individualized prevention services. California initiated their prevention program in 1974 with three regional family crisis centers and the program has now grown to a network of nearly 200 community based prevention services projects. Florida has just recently initiated the development of a comprehensive continuum of prevention services; their program is essentially in the early planning and coordination stages. Illinois has two specialized prevention programs: "An Ounce of Prevention" and "Parents Too Soon." Kansas, Louisiana, North Carolina, Ohio and Wisconsin have monies available from a Children's Trust Fund which are mandated for the development of prevention services. Vermont's Delinquency Prevention Coordinating Council awards grants for prevention programs that fit into the "State Primary Prevention Plan." Virginia has a Family Violence Program and a specified state appropriation for projects related to spouse abuse and the prevention of child abuse and neglect. The Hawaiian legislature, in 1984, established a secondary prevention services program in the Department of Health which also coordinates prevention programs provided by public and private agencies in conjunction with treatment.

Administration: Eight states have an administrative entity specifically focused on primary and/or secondary services:

California - Office of Child Abuse Prevention and a State Advisory Committee on Child Abuse Prevention
Florida - a statewide Child Abuse Prevention Task Force and eleven district task forces.
Hawaii - Child Abuse and Neglect Secondary Prevention Advisory Committee
Louisiana - an appointed board which makes recommendations regarding the disbursement of Children's Trust Fund monies and determines eligibility of programs to receive this funding
New Jersey - Governor's Task Force on Child Abuse and Neglect
Ohio - Children's Trust Fund Board

Vermont - Primary Prevention Task Force and Delinquency Prevention Coordinating Council which is responsible for monitoring and evaluation of "State Primary Prevention Plan"

Wisconsin - an independent board is appointed by the Governor to operate the program for primary prevention of child abuse and neglect

Funding: Nine states have special funds which are dedicated to the development of primary and/or secondary prevention services: Arizona, California, Florida, Kansas, Louisiana, North Carolina, Ohio, Vermont, Virginia and Wisconsin. In most states these funds are called a Children's Trust Fund. The sources of income for these funds vary from state to state and are based on various combinations of the following: state legislative appropriations; federal grants; surcharges on marriage licenses, divorce decrees, birth certificates/registrations, and death certificates; state income tax checkoffs; and donations or bequests. There was insufficient information concerning amounts of funding spent for primary and/or secondary prevention services to make any comparisons of budgets between states or to determine any costs by unit of service.

Legislation: Eleven states have legislation which establishes primary and/or secondary prevention policy, programs or funding: Arizona, California, Florida, Hawaii, Kansas, Louisiana, North Carolina, Ohio, Vermont, Virginia, and Wisconsin. Three other states have requested or are in the process of developing similar legislation: Alaska, Oregon and Utah.

Evaluation Process: None of the states submitted any evaluations of primary and/or secondary prevention programs. Seven states did confirm that they have an evaluation process for prevention services: Alaska, Arizona, California, Illinois, Ohio, Vermont and Wisconsin. The state of California has a booklet available, "Evaluating Child Abuse Prevention Programs" which may be obtained by contacting Steven C. Bailey, Deputy Director, Legislation, 744 P Street, Sacramento, California 95814.

Use of Volunteers: Only two states emphasized the use of volunteers in the delivery of primary and/or secondary prevention services. Minnesota's child welfare agency has a Volunteer Services Program Consultant who works with county social services agencies to expand and improve the use of volunteers in child abuse and neglect prevention. Wisconsin relies heavily on the participation of volunteers and paraprofessionals. Most counties have a designated volunteer director or coordinator. There is a statewide association of coordinators and a statewide organization of Directors of Volunteer Action Centers. The Wisconsin child welfare agency is gathering information on the uses of volunteers by county agencies and possible training needs in the recruitment and use of volunteers.

Program Components Which Assist the Development of Primary and Secondary Prevention Services: The state of California definitely has the most substantial system for the delivery of primary and secondary prevention services. This program has a specific administrative office which is responsible for the development of prevention projects and a State Advisory Committee on Child Abuse Prevention. There is state legislation which mandates the delivery of all levels of prevention services while also establishing specialized funding for this purpose. California also emphasizes the evaluation of prevention projects on a continuing basis to increase the quality of services delivered and to establish the most effective approaches to accomplishing prevention. Regular reporting is required which focuses specifically on the current status of prevention efforts.

All of these factors appear to be significant in establishing a quality prevention program. Two other factors of apparently less crucial impact in developing prevention services are: (1) the use of volunteers and (2) a definition which separates the prevention of child abuse and neglect into the three distinct levels of primary, secondary and tertiary. The use of volunteers is supportive to a prevention services program but is not sufficient to be relied upon as the primary resource. There are apparently a number of workable approaches to defining prevention services.

Submitted by:
Elizabeth Love, MSW
6-30-85

Summaries of responses by each of the 30 states are available upon request.

APPENDIX B

Literature Review

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INTRODUCTION

The review of the literature on child abuse and neglect prevention provides a look at two kinds of endeavors: research projects that have been carried out to determine the most effective kinds of prevention activities and to add to the body of knowledge as to what contributes to the prevention of child abuse and neglect; and, articles that describe a theoretical model or an operating program that has not been tested. Most prevention programs operate to meet some perceived community need, and they are not funded adequately to provide a truly effective evaluation component, and rarely is a budget included in a program description. Despite these limitations, a survey of the published information on prevention is helpful in deciding the directions prevention efforts should take.

Literature Review

In reviewing the literature on child abuse and neglect prevention in 1982, Helfer found only five true research studies dealing with primary or secondary prevention. "Over 85% of the articles reviewed on prevention dealt with proposals and/or trials of programs which were built upon an experiential base." It seems the body of knowledge in regard to prevention has not progressed much beyond the situation in 1982. What has been generally agreed upon by those working in the field are the definitions of primary, secondary, and tertiary prevention, that is, broadly defined: primary prevention includes activities that promote the well-being of all children; secondary prevention activities are those directed toward children at risk of becoming abused or neglected; and, tertiary prevention has as its aim eliminating the recurrence of abuse and neglect. That is about as far as the concensus among experts has developed. Otherwise, most articles call for more research to better define and evaluate factors associated with or thought to be the causes of child abuse and neglect so that prediction is possible and prevention strategies can be implemented (Starr, 1982; Schneider in Starr, ed., 1982; Martin in Starr, ed., 1982).

Much of the literature is a movement to establish child abuse and neglect prevention according to the medical or public health model of prevention (Sundel and Homan, 1979; Gelles in Starr, ed., 1982), i.e., isolating the causes of the problem and treating them. This has resulted in research efforts aimed at establishing the epidemiology of abuse and neglect, and this in turn has led to a movement to base the child abuse and neglect prevention model on "enhancing the well-being of children," similar to the holistic or wellness public health model. However, researchers and practitioners are hard pressed to come up with the definition of well-being on the one hand, or the "causes" of child abuse and neglect on the other. Some research has instead tried to establish correlations and identify factors associated with child maltreatment, and they have come to the conclusion that child maltreatment is the result of multiple interacting factors (Cohen, Gray and Wald, 1984) and that the most significant are impossible to isolate.

> Although there is some consistency across studies with respect to the association between abuse and neglect and certain of the variables studied, the magnitude of any given correlation is not great enough to indicate clearly which strategy is preferred for ameliorating the effects of a particular variable (Giovannoni, 1982).

Furthermore, in this school of thought, some studies focus on the individual (Helfer and Kempe, 1974; Gelles, 1973), and others take an ecological approach (Jansson, 1982; Nance, 1982; Kurt, 1982; Adam, 1981; Miller, 1981; Sundel and Homan, 1979; Parke in Starr, ed., 1982; Neitze, O'Connor, Hopkins, Sandler, Altemeier in Starr, ed., 1982).

The greatest number of articles are most descriptive in defining the problems in establishing a prevention policy rather than providing answers to the hard questions of what kind of prevention program works best and with whom and what are the costs. Giovannoni states the problem in regard to secondary prevention efforts:

> The research data do not elucidate to which of the numerous subpopulations effort may be directed most efficiently. Given sufficient resources, this act of clarity would not be such a problem but such an amplitude of resources is not likely. Selecting populations at risk is essentially a predictive endeavor, and there is little in the research to suggest that such predictability is even remotely near precision.

The measurement error of predictive instruments gives rise to one of the most serious ethical questions in prevention studies which is the problem of false positives, that is, identifying participating families as potential abusers when in actuality they are not. There is the social stigma attached to the label, as well as the possible creation of a self-fulfilling prophecy (Kotelchuch in Starr, ed., 1982; Cohen, Gray, & Wald, 1984). There is also much written about the problem of evaluating prevention. The most famous quote is by Bernard Bloom, who says that researchers are called on to:

> . . .evaluate the outcome of an undefined program having unspecified objectives on an often vaguely delineated recipient group whose level or variety of pathology is virtually impossible to assess. . .(from Klein and Goldston, eds., 1977).

The problem with impact evaluation is that child abuse and neglect is a low incidence variable:

> Child abuse is a relatively low incidence variable, i.e., in order to study changes in the rate of occurrence as the result of an intervention, a very large group of people would need to be studied to monitor rates of abuse.

Also:

> All the information about contributory factors is based on correlational data, i.e., we know that families high on some index of stress are also more likely to abuse or neglect their children than are families low on the same index; but we do not know that a given factor correlated with maltreatment is in fact a causal factor. Moreover, even if a factor is part of the causal picture we do not know whether altering that factor is sufficient to prevent abuse or neglect (Cohen, Gray, and Wald, 1984).

However, the literature does provide some direction for developing prevention programs. Two well-known studies with positive results are:

> --The classic study in preventive methodology was performed by Gray, Cutler, Dean, and Kempe in the mid-1970s. High risk and low risk new mothers were identified, and out of a group of 350, 50 were randomly assigned to a non-intervene group and 50 to an intervene group. There were significant differences in the rates of reported abuse in the two groups.
>
> --O'Connor and colleagues also had significant outcomes in a study of rooming-in after the delivery of a first-born child.

Cohen, Gray, and Wald provide a review of research that is more up to date than Helfer's. And, for the most part current literature reflects outcomes that are negative or equivocal:

1) Early and Extended Contact

   Studies from 1977 - 1980 are noted. The two review studies are Goldberg, 1983 and Lamb & Hwang, 1982. Two studies are also highlighted: O'Connor, Vietze, Sherrod, Sandler, & Altemeier (1980); and Siegel, Bauman, Schaefer, Saunders, and Ingram (1980). The first noted a significant difference in the treatment and control groups; the second did not.

   It is concluded that more data about the effects of early contact is needed. It is also noted that no harmful effects resulted from the intervention strategy.

2) Perinatal and Other Support Programs

   A survey of broad ranging interventions is presented: Seigel et al.; Gray, Cutler, Dean, and Kempe, 1977; Gray et al.; Harrison, 1981; Spearly & Lauderdale, 1983; Garbarino & Sherman, 1980; Pillai, Collins, and Morgan, 1982.

   It is difficult to know which aspects of the various programs might be responsible for any benefits.

3) Parent Education Classes

This is a commonly used and proposed strategy. Programs include: 1) pointing out infant capabilities to parents to engender a sense of parental pride, 2) informing parents that how they interact with their baby is important for the child's future development, 3) alerting parents to indications of child stress and teaching them how to alleviate it, 4) imparting general child development principals.

No studies of education programs use rates of abuse and neglect as outcome. Studies cited are: Avance Parent Child Education Program (Gray, 1983a; Rodriguez, 1983); Education for Parenthood Program begun in 1972 by the Office of Child Development, Office of Education and National Institute of Mental Health; 7 out-of-school demonstration programs set up by such as 4-H Club and Save the Children Federation evaluated by Behavioral Associates (1977); Inter-Act: Street Theatre for Parents (Gray, 1983b).

Most of these studies measured changes in attitudes on a short term basis.

Counseling Programs:

Another commonly utilized intervention seeks to provide some type of counseling or therapy to an identified group of people in order to reduce the chances that they will maltreat their children.

This group includes known abusers. The entire body of literature is not reviewed. The report is only about one study that used extensive counseling with parents who had not yet abused their children but who were identified as being at risk of abuse or neglect, and on two studies which had modest success in changing the behavior of parents who had already abused a child.

Studies: 1) Gabinet (1979) on an outreach program focused on serving inner-city, low-income women in their homes, 2) Reid et al. (1980) on using behavior modification techniques with families who were already abusing their children, 3) Patterson (1976), 4) Burgess and Richardson (in press).

All the studies reported favorable or partially favorable results. However, there are questions as to how these interventions can be applied to prevention with regard to identifying clients. Also in question is the stability of the changes in the families. One last consideration is the prohibitive cost of such intervention.

Directions for Program Planning

There is no doubt that the approach to designing a program (as well as the lack of a design or plan) will critically effect its results, and many people in the local communities throughout Texas will not have the resources to help them with all the design steps recommended by the literature. Problem definition and target groups will not be allocated a great deal of time.

In face of the dilemma presented by the stringency in testing hypotheses called for by the researchers, and the demands for specific "how to" information from local community members, some preliminary criteria for program development are suggested by the review. However, they are suggested with caution. Since much of the literature is "armchair speculation," termed so by one of the few true research studies found by Helfer, anyone's guess is as good as another's in the realm of most of the services designed as preventive.

First, the realm will be presented, and then a few comments of what is known that might narrow the spectrum somewhat. Also included will be considerations that should be given when initially considering a prevention program. These last will attempt to be presented without lapsing into the philosophical or moral that so many working in child abuse and neglect prevention end up using as a last refuge against the hard questions.

Possible Prevention Activities Suggested by the Literature Review:

1) Crisis Nursery
2) Public Awareness Campaign
3) Maternal & Infant Support or Perinatal Program
4) Teen-age parent Program
5) Stress Line Telephone Counseling or Parents' Warmline
6) Parenting Program
7) Program for Divorcing Parents
8) Family Counseling
9) Programs for families with infants who are ill or developmentally disabled
10) Programs aimed at disadvantaged mothers, such as "Home League" of Salvation Army
11) Parenting programs aimed at groups culturally different from American society
12) Parent-aides (in home services)
13) Healing programs for abused or neglected children and adolescents and adults (who are potentially parents themselves)
14) Legislative advocacy
15) Children's Trust Fund
16) Family Planning
17) Day Care
18) Community Information and Referral

19) Mental Health Education
20) Employment counseling
21) Community Support Networks
22) Health Services, EPSDT
23) Comprehensive emergency services
24) Neighborhood recreation services
25) Big Brother/Big Sister programs
26) Public school sex education
27) Life/Career planning courses for adolescents

Comments:

What can be determined from the literature review is that Gray, Cutler, and Kempe's work with mothers who were provided care by a physician, and a lay health visitor or a public health nurse for two years follow-up was successful, and that O'Connor's work with parent-child interaction in rooming-in after delivery was successful. Also, Thomasson et al., 1981, used an "ecological model" to devise a preventive program for rural parents. Using the Child Abuse Potential Inventory devised by Milner and Wimberley (1980) as a dependent measure, they were able to show a significant improvement in the subject's scores over time.

There are also studies whose results were not so dramatic or whose methodology was not so error free, but their efforts were perhaps more ambitious, such as Gabinet's work in Metropolitan Cleveland with young, needy, adolescent mothers, or Gladston's work with abused children. Other kinds of efforts, such as parent's stress lines, or parent education have either no evaluation at all or equivocal results; however, these programs have been and continue to be well received in communities, have become common curriculum in neighborhood groups or community education classes, or church groups. One relatively new area is parent education included in life skills courses for adolescents. There is some suggestion that attendance by adolescent males is very low for these classes, and that unless the classes are mandatory, they are ineffective, and perhaps are still ineffective even if mandatory because motivation of the participants is low. It is agreed within the literature that the time when participants are most motivated to learn parenting skills is when they are becoming parents for the first time or perhaps the second time.

Two other areas in which there has been some success noted in the literature is work with parents of groups who are cultural minorities within American society and Street Theater aimed at parent education. Street Theater showed immediate, dramatic results in changing parents' attitudes toward discipline and expectations of children. Ethnic parent education classes focus on the clash of cultural values of a minority group with the mainstream American cultural values surrounding adolescent behavior.

An area not tested, but also receiving wide acceptance, is the work with parents who have an ill or developmentally disabled infant, as well as programs for divorcing parents or for children of divorcing parents.

In the area of legislative advocacy, an activity that has gained some acceptance with states is the establishment of Children's Trust Funds. These have worked well where they are in operation, and provide a sources of funds that are separate from the established programs within a state, and provide a base for innovation in program planning.

Conclusion

This review does provide some helpful information in planning for prevention activities. One of the first considerations is whether prevention efforts will be directed toward the general population or toward some identified at risk group. This is a consideration that needs to be determined at the local level and tailored to each community. For instance, it seems that work with at risk groups would be most fruitful in large urban areas; whereas, in rural areas where the population is not so concentrated, prevention efforts might more efficiently be directed toward the general population. The target group, namely its size, will effect the services being offered. It is obvious that intensive behavior modification counseling cannot be offered on a one to one basis to the general population. However, each community should be able to identify factors that they believe are associated with abuse and neglect in their area, and should be able to define the prevention activities that are relevant to their community. It will do the community little good to know what was most successful for researchers if the hospital in the area is not ready to provide perinatal or friendly visitor programs to new mothers. However, if the community is looking to someone for advice when they are confronted with the possibility of many moves that could be made in regard to prevention, the literature does give some direction, albeit some of it in a negative or equivocal way.

The following sections provide information in specific areas that should be considered when planning a prevention program.

Prevention Factors

Introduction

In deciding what kind of child abuse and neglect prevention program to design, one approach is to consider the factors that are associated with child abuse and neglect and develop a program which effectively deals with one or more of those factors. Although the literature does not provide research that can be described as establishing a causal link between certain factors and child abuse and neglect, there are strong suggestions of associations between certain factors and the abuse and/or neglect of children. The factors are interrelated and this complicates the situation; however, research and practice during the last ten years or so have added to our knowledge of the etiology of child maltreatment.

This approach to the definition of the problem of child abuse and neglect has been developed following the framework of the public health model of prevention which is designed to determine the causes of the problem and to treat the causes as one would in isolating the causes of an illness and treating them to make the person well. There are some limitations to this approach in that it has been difficult to isolate the causes of child abuse and neglect and to determine which are the most significant variables. It seems that child maltreatment is the result of multiple interacting factors.

Descriptions of the factors and their relationships can be found in much of the literature; however, four sources were selected for this section. They were chosen because they included a review of articles and studies, or were more comprehensive than other work or attempted to integrate etiological findings into a system that could be operationalized for practice.

I. In Cohen, Gray, and Wald, 1984, a review of prevention factors in the literature is provided. The following is a summary of the article:

The four factors associated with abuse and neglect for which there is evidence most suggestive of a causal connection: reading of the literature suggests:

1) aberrant childhood nurture of the parent
2) early (i.e. prior to maltreatment) attachment problems
3) aggressive tendencies in relationships
4) high levels of stress

It is quite likely that these are interrelated; thus, the causal picture is complicated and it is likely intervention that influences one will to some extent influence the others. Furthermore, none of the causal relationships are 100% correlated so that each factor is only part of a very complex picture.

Relating Causal Theory and Prevention

1) Direct causal mechanism: early bonding or attachment. Programs which promote bonding or attachment are likely to have an effect of reducing abuse: rooming-in (birthing rooms, etc. and hospital policy; perinatal support programs; day care with mother present).

2) No direct causal mechanism: aberrant childhood nurture and violence proneness. Knowledge enables an identification of high-risk groups but does not tell how to focus prevention. Various intervention techniques: counseling; behavior modification; high school classes in parenting and child development; parent education classes for adults; home visiting programs including those that are at least partially aimed at providing services to child victims. The strategies have two goals with respect to aberrant childhood nurture and to tendency to aggression in personal relationships. Differences arise as to whether the mechanism for action is in personality change or in provision of alternate techniques for managing children.

There are probably many different causes of child maltreatment; there are probably many ways to prevent abuse or neglect, depending on what cause is suspected and who the target population is. Currently, based on research, the at-risk population cannot be identified as to group and what intervention is appropriate.

The absence of direct evidence requires other indices of success or failure. These indices are derived from knowledge of causes of maltreatment, which is relevant to prevention in two ways:

1) all prevention programs should be (and usually are) based on some notion of what causes the problem. To the extent that a causal link exists between a given variable and child maltreatment, an intervention strategy effecting that variable should be an effective preventive measure.

2) knowing those factors that contribute to the likelihood of abuse and neglect provides a set of intermediary variables to use in evaluating prevention programs. If a program does not include a report on the actual incidence of abuse or neglect, it may report change on a factor that is thought to contribute to the likelihood of maltreatment. We can view a program as successful if it alters such factors. Such evidence must be viewed cautiously, however.

Summary

The complexity of abuse and neglect means there will not be just one successful way to intervene. There will be many effective prevention strategies. However, not all prevention measures will work in all populations. Therefore, designing a prevention program for a particular community means one should think about what the most likely causes of child maltreatment are in that community. Any prevention efforts should address that cause.

II. "Prevention in Child Welfare: A Framework for Management and Practice," Sundel and Homan

This article bases its approach to prevention on the public health model and suggests a framework for designing, implementing, and evaluating a child welfare prevention program. Adapting public health concepts to child welfare service activities, it provides a method for designing a program.

An elaboration of the framework on which this article is based is shown in the following table, which presents interventions according to levels of service activity for five major problem areas. Because service definitions are not widely standardized and problems can be interrelated, the interventions shown in the following table do not always fall exclusively into the categories of primary prevention, early intervention, and treatment and rehabilitation. Furthermore, in many cases, empirical research linking particular services to either prevention or successful treatment of specific problems is lacking. This conceptual scheme, however, provides a framework to help program administrators identify and plan services and programs appropriate for target populations at different stages in the development of social problems.

A Problem-Oriented Framework for Child Welfare Intervention by Level of Service Activity

		SECONDARY	TERTIARY
PROBLEM	PRIMARY PREVENTION	EARLY INTERVENTION	TREATMENT AND REHABILITATION
Family Breakdown	Legislative advocacy Parent education Family planning Day Care Community information and referral Mental health education Employment counseling Community supportive networks Mental health consultation	Outreach programs Family counseling Day care Hot lines Mental health services Financial aid Transportation Legal services	Family therapy Divorce counseling Legal services Court studies Single parent support groups Foster family care

Abuse and Neglect	Legislative advocacy Parent education programs Community supportive networks Mental health education Employment counseling Public awareness campaigns Mental health consultation	Health services, EPSDT Family counseling Day care Hot lines Homemakers Comprehensive emergency services Financial aid Mental health services Transportation Parents Anonymous	Homemakers Family therapy Foster family care Self-help support groups Legal services Court studies Group homes Adoption services
Status Offenses and Delinquency	Legislative advocacy After school day care Community supportive networks Neighborhood recreation programs Youth employment programs Big brother/sister programs Mental health education Mental health consultation	After school day care Outreach programs Family counseling Hot lines Comprehensive emergency services Educational services Mental health services Transportation	Family therapy Foster family care Day treatment programs Group homes Runaway shelters Legal services
Teen-age Pregnancy	Legislative advocacy Family planning services Public school sex education Life/career planning courses Community information and referral Mental health education Employment counseling Mental health consultation	Family planning services Family counseling Hot lines Health services Educational services Independent living programs Transportation	Family planning services Education for parenthood Family therapy Legal services Health services Group homes Adoption services

Drug/Alcohol Abuse	Legislative advocacy Parent education Public school education Community supportive network Neighborhood recreation programs Community information and referral Mental health education Mental health consultation	Health services Mental health services Family counseling Hot lines Drop-in centers Ala-Teen Transportation	Day treatment programs Family therapy Self-help support groups Group homes Residential treatment

III. In his book, Child Abuse Prediction: Policy Implications, Raymond Starr reports on variables he found significant in a study of two groups of multi-problem families. The results of the study reported in this chapter, "A Research Based Approach to the Prediction of Child Abuse," suggest that when abuse and control groups are carefully matched on a case by case basis, much of the existing literature describing the causes and correlates of child abuse is not supported. Few group differences were found and, where they were present, they generally did not follow a pattern that led to a coherent explanation of child abuse in terms of social, parental, or child variables. Indeed, when the large number of statistical analyses performed in this study are considered, it is likely that many of them are the result of chance factors. That is, 5 percent (thirteen) of the analyses performed would be expected to be significant due to chance. Overall, sixteen of the twenty-six significant variables were significant at the p .01 .05 level. Since chance cannot be separated from "real" significance, all of these variables are considered as nonsignificant due to random factors. Only the following ten variables, significant at p .01, are considered significant.

1. Whether mother has ever been employed full time;
2. Whether violent disagreements lead to hitting or throwing;
3. Number of different people visited;
4. Whether meet with relatives more than once a week;
5. Whether these meetings are often enough or not;
6. Whether there is denial of emotional complexity in child rearing;
7. Maternal rating of overall child health;
8. Likelihood that low child weight is due to neglect;
9. Overall rating of likelihood of neglect; and
10. Hemoglobin levels.

Only two clear relationships were present within this set of significant findings. First, there were group differences for three social isolation variables: number of people visited, frequency of meeting with relatives, and whether or not this is often enough. Two of these three variables were significantly intercorrelated: number of people visited with number of times the parents met with relatives, r (168) = .281, p .001; and frequency of meeting with relatives with whether or not this is often enough, r (170) = .297, p .001. These findings support the conclusions of such investigators as Garbarino (1976, 1981) that abusive families are more isolated. However, the present findings of greater isolation are not supported by significant differences in other, logically related areas. For example, mobility as assessed by frequency of moves during the past year and five years was unrelated to isolation or feelings of isolation. Families who moved frequently did not meet less often with friends and relatives. Finally, it should be noted that there were no group differences on a number of other measures of isolation, including the availability of such familial and neighborhood social supports as help in times of need or with child care. The CA families were more isolated than the CN group families, but they were not without friends and social supports. The differences that are present are ones of degree, not kind.

The second set of significant group differences was related to child health. The most important finding was that abused children were significantly more likely to be neglected. These results thus support the conclusion of other researchers that abuse and neglect often accompany each other (Steele, 1980; Wolock & Horowitz, 1979). Furthermore, it should be remembered that physicians' ratings of whether or not a child's low weight was due to neglect and their overall rating of the likelihood of neglect were highly correlated. This finding was not surprising in that the same individuals performed the two sets of ratings and it was only logical that a child who was seen as having low weight due to neglect would also be seen as neglected in general. Measures of the two other significant health related variables, hemoglobin levels and ratings of overall child health, were not correlated with either neglect measure. It is not surprising that overall health was unrelated to neglect since the CN group was selected from among children with health problems. However, the lack of a relationship between low hemoglobin levels and neglect was surprising. At the present time there is no easy explanation for this particular result. In any event, however, it should be remembered that the relationship between neglect and abuse is a correlation of no explanatory usefulness. That is, this relationship helps us understand child abuse but does not help us predict it beyond suspecting that a child referred for service because of neglect should also be considered as being at risk for abuse.

Two of the three remaining significant findings appear to have substantial face validity. It is not surprising, in view of the existing literature on child abuse, that the abuse group mothers reported more arguments with their mates that led to hitting and throwing objects. Indeed, mothers' answers on this question were positively correlated with the frequency with which they physically punished their children, r (64) = .431, p .001; the extent to which they yelled and induced guilt in their child as a discipline strategy, r (67) = .334, $p = .003$; and the degree to which their mothers used the same strategy with them when they were children, r (67) = .346, $p = .002$. The finding that CA group mothers perceived child rearing in overly simplistic terms, which were likely to lead to frustration upon experiencing raising children as a difficult, demanding challenge is also not unexpected. The remaining variable, the decreased likelihood that an abuse group mother had ever held a full-time job, is hard to interpret. While this result could be due to chance factors, it could also reflect a more global inadequacy on the part of the abuse group mothers. Tables 4-2 and 4-3 show that when nonsignificant results are considered, the CA group mothers tended to function less well than the CN mothers. Thus, while there were few significant differences, the CA group mothers typically were worse off than the CN mothers. They were younger, had their first child at a younger age, were poorer, were less likely to be married, had a higher incidence of social deviance, were more isolated, moved more, were disciplined in ways judged to be too severe during childhood, were less intelligent, were more likely to have personality problems, had maladaptive child-rearing attitudes, and provided a less child-centered home environment.

If this maternal social and psychological inadequacy hypothesis is accepted, the findings of the present study are easily interpreted. While there are few significant differences for individual variables, examination of the direction of other, nonsignificant differences suggests that mothers in the abuse group are generally functioning less adequately. It is as though the data profiles for the two samples are essentially parallel, with the scores for the abuse group mothers generally exceeding those of the control group; but rarely to a degree that reaches statistical significance. While it would be desirable to analyze the sum of these small group differences, this has not been possible. Thus, attempts to construct scales using the present data have failed, as have factor and cluster analyses.

The results of this study have implications for our conceptualization of child abuse. Prior research has been based on clinical data that tended to verify the clinicians' operating hypotheses without the benefit of comparisons with a closely matched control group. Even more adequately controlled research has focused on relatively few variables. To return to the elephant analogy with which this chapter started, it is as though several investigators were studying differences between Indian and African elephants. One group looked at trunks, another at ears, and a third at tails. Each group found some significant differences as a result of their investigations. However, a fourth group looked at the whole elephant and made a large number of detailed measurements, all of them as detailed as those being made by the researchers in the three, more limited studies. The conclusions of this fourth group were that, yes, there are differences between Indian and African elephants, but they are minor; and, most importantly, the animals in both groups are still elephants who are, in reality, quite alike with considerable overlap for all measures, even those on which there appeared to be significant differences.

The issues involved in the present study are not ones of precision of measurement. The measures and questions used were similar to those employed in studies where significant differences have been reported albeit without the benefit of an adequate control group or a relatively large sample size. We have studied two groups of families who are more alike than they are different. Both groups contain a high percentage of multiple problem families who have major difficulties in existing from day to day. They are poor, have health problems, move frequently, live with a high degree of stress, and so forth. Given the difficulties involved in developing a reliable and valid predictive instrument, child abuse will only become less of a problem in low income, multiple problem families when we develop ways of improving their quality of life in general and, more specifically, correcting the deficiencies in parent-child interaction patterns that have been observed in subsamples of the families involved in the present study (Dietrich, Starr, & Kaplan, 1980; Dietrich, 1981) as well as by other investigators (Burgess & Conger, 1978; Vietze, Falsey, O'Connor, Sandler, Sherrod, & Altemeier, 1980).

IV. "Individual, Family, Community, and Cultural Factors Associated with Child Maltreatment," by Deborah Valentine, Theresa Andreas, and Dianne Acuff

This extensive literature review of the etiology of child maltreatment uses an ecological model to analyze the factors associated with child abuse and neglect. The model allows for the integration of varying perspectives on the study of child maltreatment and is divided into the following sections:

Child Factors--These studies point to viewing child abuse from a transactional perspective and as a bi-directional process rather than a uni-directional one which focuses only on parent behaviors or traits. It has been found in the research that children with the following characteristics are over represented among children who are abused and neglected.

1) Perinatal Considerations

premature birth
low birth weight
special medical needs
Caesarean birth or especially difficult labor

2) Physical and Developmental Considerations

- anemia
- neurological abnormalities
- under-nutrition
- visual problems
- illness at infancy
- mental retardation
- language delays
- perceptual-motor immaturity
- learning disabilities
- physical handicaps
- intestinal malformation
- hearing defects
- cleft palates
- brain damage

The experience of caring for the special needs child may be frustrating and cause the parent to harm or reject the child. Also these children may be less responsive to comfort and nurturance because of their special conditions and add further stress to the parenting role. A child's physical appearance may increase the occurrence of abuse. Dion (1974) reports that the degree of adult punitiveness is determined by the physical attractiveness of the child, with the unattractive child receiving more severe punishment than an attractive child.

3) Child Behavior and Temperament

This section describes the "difficult child."

- irritable
- negativistic
- demanding
- unresponsive
- overly dependent
- hyperactive

The older difficult child:

- hyperactivity
- aggressive behavior
- stealing
- truancy
- running way
- sexual acting out

4) Child's Status within the Family

- unplanned
- out-of-wedlock
- adopted
- negatively identified with a familiar person who is disliked

a child may be rejected because of:

- sex
- looks
- capacities
- status or circumstances of birth

Parent Factors

"The majority of research investigations over the past twenty years have been attempts to describe and document specific characteristics of individuals who are perpetrators of child maltreatment. For the most part, these research efforts have focused on parents. They have lacked vigorous research design, being primarily ex post facto, have utilized poor sampling techniques, collected data through self-reports and have lacked control groups."

1) Ontogenic Factors

history of maltreatment in their own childhood
nurturance mothers reported receiving consistent predictors of children's failure to thrive
childhood exposure to violence, aggression and negligence
lack of experience in child care
general experience of parental rejection or attachment failure

2) Attribute Variable

Age: the association between adolescent parenthood and child maltreatment has been demonstrated in the research; the adolescent has limited resources in dealing with the repeated crises and stresses of teenage pregnancy and parenthood

Gender: abuse is inflicted in about the same proportion by mothers and fathers controlling for rates of involvement in child care; however, research focuses on mothers

Education: levels of education of maltreating parents are markedly lower than the general population; parents with no secondary school education are overrepresented

Ethnicity: parents identified through public welfare programs include a larger number of minority individuals than is found in the general population

3) Substance Abuse

An association of substance abuse with child abuse and neglect is mentioned in the literature; however, this association has not been explored within a research context. It is not possible to determine if alcohol is a causal factor of child maltreatment. It is clear, however, that situations in which one or both parents are engaged in the chronic abuse of drugs or alcohol are consistent with situations in which child abuse and neglect commonly occur.

4) Personality Traits

> "Overall, the personality traits consistently reported as being associated with child maltreatment are few. Due to the ex post facto nature of the research, it also cannot be determined if characteristics such as low self-esteem and unhappiness which describe abusive parents are 'consequences' of abusive acts and subsequent social service intervention rather than 'causes' of abuse."

The literature suggests that only a small number of abusive parents can be classified as mentally ill or as psychotic.

role reversal: adults and children
    husband and wife
low self-esteem
higher frustration of needs
social isolation
paranoid-like thinking
depression
impulsive behavior
emotional immaturity
low frustration tolerance
rigidity in thought patterns and behavior
high, unrealistic expectations of children
lack of ability to emphasize with children

Child abuse by fathers is typically accompanied by spouse abuse and also be excessive drinking.

5) Parenting Skills

A pervasive assumption in the literature is that parents who abuse their children show lack of knowledge about child development, and have unrealistic expectations of the child's capabilities.

child's failure results in parental frustration and aggression
view children as much older than their chronological age

However, one study suggests there is no difference in the expectations of abusers and non-abusers, and that the premature expectation hypothesis be replaced by a more specific investigation of parenting behavior.

limited range of parenting skills and disciplinary tactics other than physical punishment
attitude of "owning" the child
behavior of very young children regarded as willful
parent gains nurturance and sense of worth from child
demonstrates more physical aggression and more negative commands

Family Factors

1) Family Structure

Families with four or more children are reported more frequently for abuse and violence increases in dense, crowded living spaces; there is a link between large family size and maltreatment, including factors such as little separation between ages of children and the highest abuse rates in families with five children. Step families are overrepresented in abusive/neglectful families; step parent families appear to be more prone to episodes of child sexual exploitation. Single parent families are an indicator of child maltreatment.

2) Parent/Child Interactions

The most dangerous period for child abuse is from age three months to three years. Parent-child interaction factors associated with child maltreatment include: lower rates of interactions with the child or maladaptive relationships between abusive family members; and poor parent-infant bonding or attachments in abusive families. A "good" competent mother can compensate for a "difficult" baby or a "well-endowed" infant can offset the shortcomings of less than ideal mothering; in reverse, a "difficult" baby can elicit negative mothering behaviors in an otherwise competent, well adjusted mother.

As a child grows older, the child's share of contributing to the parent-child interaction increases. Child maltreatment may be the result of an escalating cycle of inconsistent discipline, continuation of child behavior, parent's perception of child as hostile and aggressive, and acceleration of punishment intensity. A large-scale, systematic study supports the idea that child abuse is almost invariably precipitated by some behavior on the part of the child which initiates disciplinary interaction, culminating in abuse. Sameroff (1975) presents a transactional model for understanding and evaluating behaviors and interactions.

Parent-infant bonding and early attachment behaviors have also been researched. Gray et al. (1976) list high risk signals in the delivery room which include:

a. lack of interest in the baby, ambivalence, passive reaction
b. keeps the focus of attention on herself
c. unwillingness or refusal to hold baby, even when offered
d. hostility directed toward father
e. inappropriate verbalizations, glances directed at baby, with definite hostility expressed
f. disparaging remarks about the baby's sex or physical characteristics
g. disappointment over sex or other physical characteristics of the child

3) Marital Relationship

Research indicates that marital conflict and discord run high in abusive households. The two are seen to be linked in various ways. Stress and conflict in the marital relationship may spill over into the parent-child relationship; children may become the focus for anger and aggression in family conflict, and thus emerge as scapegoats.

Families who use physically and verbally aggressive tactics to resolve marital disputes tend to use similar tactics to discipline children. Child abuse by fathers is typically accompanied by spouse abuse, and often the more violent husbands are toward their wife, the more violent the wife is toward her children.

4) Interaction Between Family and Situational Factors: Family Stress

- family stress
- parental unemployment
- poverty and financial insecurity

Community and Neighborhood Factors

1) Social Isolation

Mothers in abusive families visit fewer people on a regular basis, make fewer total visits, meet with fewer relatives, and are less likely to feel that they meet with relatives often enough. Lack of participation in organizations and church attendance are also suggested as factors contributing to increased risk for child maltreatment.

Abusive and neglecting families are less likely to have a phone than non-abusive/neglecting families.

2) Support Systems

It is the unmanageability of the stress which is the most important factor and unmanageability of the stress is a product of the mis-match between the level of stress and the availability of potency of support systems. Isolation from potent support systems is viewed as a necessary condition for the occurrence of child maltreatment.

Support systems consist of: informal social networks; emotional and material exchanges; role models; social networks as enforcers of community standards of child rearing; formal support systems.

3) Community Economy

Overall rates of abuse are higher in areas characterized by unusually high rates of unemployment.

4) Urbanicity

Urban environments present obstacles to the healthy development of children and to the maintenance of the family. High density populations and overcrowding tend to discourage formation of support networks.

Cultural and Societal Influences

Society's attitudes toward violence, corporal punishment, and children are defined as the most evident macrosystem variables in fostering child abuse and neglect. These attitudes include:

- societal sanction of physical force as a resolution of conflict
- societal sanction of the use of corporal punishment
- societal attitudes toward children, such as, children are chattel to be treated by parents in any way they see fit, childhood is a totally carefree time, children exist for parental gratification, and that parenting is an innate ability.

Summary

Use of the information in the articles and books summarized above must be tempered with caution and viewed carefully in regard to its limitations. Most of the studies used to compile the reviews above provide evidence only of association between certain factors and child abuse/neglect. One must be careful not to interpret the data as evidence of causality.

Although research on correlational data has not provided us with definite answers as to the causes of child maltreatment or as to what variables are most significantly associated with child maltreatment, it has been shown that work on the prevention of child abuse and neglect has reduced the severity of abuse and neglect in individual cases.

Therefore, even if the direction that prevention efforts should take to obtain the best results is not clear at this time, work with families can be undertaken with some assurance that positive results can occur by looking at the factors associated with child abuse and neglect.

Definition of Primary Prevention and Program Design

Prior to designing a child abuse and neglect prevention program, there is some general information in the literature that should be considered. There are several articles that present theoretical models for planning prevention programs. These articles are of two kinds. While they are articles that are descriptive rather than research articles, some are descriptive of prevention factors associated with child abuse and neglect, and some describe models that are not based on the treatment of "causes" or factors associated with child abuse and neglect. The preceding section entitled "Prevention Factors" covers the models based on determining the causes of child abuse and neglect. The following section will include the articles that find the model based on the causes or factors too limiting.

Also, examples of articles based on promoting "wellness" rather than the prevention of "illness" follow. Giovannoni, 1982, describes the difficulties in using the classic public health model in child welfare agencies.

PROBLEMS WITH THE PUBLIC HEALTH MODEL

The public health model is used to characterize infectious diseases that easily fit into clear, measurable features:

> a single identifiable organism that can be isolated and understood in the laboratory, populations that can be identified as being at risk of attack from the organism, preventive strategies that are developed on the basis of knowledge about the organism, a disease with a predictable course and duration, and one with sufficiently uniform manifestations that it can be diagnosed with great accuracy.

The problems in applying the above model are outlined from Giovannoni's article:

1) Circumscribing the Disease

The establishment of incidence and prevalence has proven to be difficult due to disparities in the definition of child abuse and neglect from state to state, and community to community. Also, there are numerous subcategories to the global terms child abuse and child neglect. Two national studies, one by Gil and one called the National Study of the Incidence and Severity of Child Abuse and Neglect, exemplified the issues in operationalizing the terms describing incidence.

> In short, the use of official reports as a measure of incidence is generally conceded to be unreliable. Cholera may be cholera in Bombay or San Diego, but child abuse may not be child abuse in San Diego and Los Angeles counties.

> Obviously, these factors raise serious questions as to whether a phenomenon that is so dependent on external social circumstances for its very definition should even be considered a "disease." But, even if such a stance is maintained, a practical problem exists. Establishing incidence rates and prevalence rates or designing cases as being before or after the "stage of onset" calls for special efforts to collect data that can be expensive and complex. This is so whether one is trying to establish national incidence rates or incidence rates in a given community or service catchment area. That the phenomena can be circumscribed and operationalized has been demonstrated. But, whether the boundaries of the definitions have a widespread social meaning remains problematic.

Finally,

> In sum, circumscribing the disease or even the diseases that may be considered child abuse or neglect, whether for the purpose of establishing incidence or prevalence rates, determining the stage of onset, or designating interventions as "primary," "secondary," or "tertiary," is complex. Yet, if the model is to be followed, these complexities must be dealt with; without the clear circumscription of what is to be prevented, all concomitants of the model break down.
>
> 2) Causation
>
> Crucial to the concept of prevention in public health is the idea of cause. In the case of acute infectious disease, as noted, there is a single, identifiable organism. How valid is the concept of causation when applied to child abuse and neglect or to other social problems? . . . the many and diverse phenomena that may be considered child abuse or neglect clearly indicate that a search for a single cause, or even a set of causes common to all, would be in vain.

Research efforts have been directed toward establishing an epidemiology of abuse and neglect.

> With respect to internal functioning versus environmental precipitants, the research has produced correlations between mistreatment and factors indicative of intrapsychic functioning, interpersonal functioning, and various levels of external environmental factors. In one analysis of research on the etiologic correlations of child abuse and neglect, Simkins et al. posited an ecological model of the relationships of factors that may produce child abuse and neglect.
>
> Other reviews confirm the stance taken by Simkins et al. They suggest that child mistreatment is best seen as the "result" of

multiple interacting factors, including the parents' and children's psychological traits, the family's place in the larger social and economic structure, and the balance of external supports and stresses, both interpersonal and material. Further, it does not appear that uniform kinds of associations have been found among the sets of variables and different types of mistreatment. For example, it has been demonstrated repeatedly that physical neglect is more closely associated with single-parent status than is physical abuse. Thus, to say that one is dealing with "multiple causes" oversimplifies the matter. Rather, one is dealing with multiple and diverse effects that are associated with different configurations of the same variables.

What the existing research does not elucidate (nor could it reasonably be expected to do so) are the nature and direction of the relationships among the variables and their relationship to the occurrence of the various manifestations of mistreatment. The correlates, themselves, are perhaps best thought of as a chain; with the addition of each link, there is an expected increase in the probability of the occurrence of mistreatment. However, it is not known which links are more important than others in breaking the chain. As Cohn and Garbarino observed: "We know something about who abuses and neglects, but we don't know why." And the "why" is the essence of the causal model.

3) Selecting Populations at Risk

The available data on this topic are both useful and problematic. They are perhaps more useful in indicating where social workers will be relatively less effective in targeting their efforts than where they should focus them. For example, efforts to prevent physical neglect should be least effective if targeted at middle-income two-parent households. They are problematic because designating populations at risk from what is known (singling out one or two known, associated characteristics) still leaves a large population from which to delineate the subpopulation truly at risk. Families who mistreat children are a relatively small subset of any of these groups (for example, of all low-income mothers). Added to this is the problem that the apparent relevant populations are multiple and diverse; any intervention strategy aimed at a given population has the potential to reduce mistreatment only by the fraction of the total cases that may be perpetrated by that subpopulation. The research data do not eludicate to which of the numerous subpopulations effort may be directed most efficiently. Given sufficient resources, this act of clarity would not be such a problem, but such an amplitude of resources is not likely. Selecting populations at risk is essentially a predictive endeavor, and there is little in the research to suggest that such predictability is even remotely near precision.

4) Selecting Intervention Strategies

Determining intervention strategies on the basis of existing research is even more of a problem than selecting populations at risk. First, there is a mass of correlational data. Although there is some consistency across studies with respect to the association between abuse and neglect and certain of the variables studied, the magnitude of any given correlation is not great enough to indicate clearly which strategy is preferred for ameliorating the effects of a particular variable. Hence, the researcher must proceed on a hit-or-miss basis. In essence, researchers cannot order the importance of the variables or even distinguish those that are independent from those that are intervening.

CHARACTERISTICS OF PREVENTION PROCESS

In "A Descriptive Definition of Primary Prevention," 1981, Adams proposes an alternative method of program design and evaluation in that he bases his plan on something other than the medical model, or problem reduction or causal link method of defining and evaluating prevention programs. He suggests characteristics of the prevention process as a basis for planning, implementing, and evaluating a program; and, he describes a framework based on these characteristics which can be used for process as well as outcome assessment:

Definition: Prevention can be described as a complex set of activities aimed

a) at developing the personal and social competencies of people, and

b) at modifying social systems to better meet the needs of people (Cowan, 1977).

2 Levels

1) Action directed toward individual, social, economic, and cultural influences which are assumed to contribute to the emergence of individual dysfunctional behavior

2) Conversely, modified to contribute positively to the emergence of wholesome personal and social behavior.

Characteristics:

1. Proactive 2. Generic	General characteristics, which distinguish prevention from treatment
3. Developmental	Characteristics pertaining to individuals and families who are

4. Experiential	usually considered to be the "target population" of wellness and prevention activities
5. Systemic	Characteristics pertaining to the environment, or the social institutions which serve as support systems and resources to the target population
6. Collaborative	

Proactive

Activities are conducted among well target populations and generally affect large groups of people rather than being conducted among already distressed populations treated individually or in small groups.

Generic

1) increasing the competencies of people
2) favorably altering the environment to meet people's needs

These dynamic growth processes are not problem-specific because they are not determined by the nature of the problem being "prevented." Thus, activities which 1) foster the development of basic life skills, and which 2) favorably alter social institutions will appear similar--and may in many cases be the same--whether the process aims at prevention of juvenile delinquency, alcoholism, smoking, truancy, or child abuse. These activities aim at preventing the causes of specific problems by increasing the strengths of individuals and institutions.

Developmental

Prevention programs must foster the personal development of individuals by intentionally promoting and attempting to measure their growth in one or more of the following (listed under "Factors Section").

Experiential

New ideas and skills are best learned when they are perceived as directly relevant to the individual's life experiences. Workers should utilize this principle to tap motivation of participants. Involve participants from the beginning planning, through implementation, to final evaluation.

INTERVENTION AT MULTIPLE LEVELS

In Chapter 2 of Child Abuse Prediction: Policy Implications, "Theoretical Models of Child Abuse: Their Implications for Prediction, Prevention, and Modification," Ross D. Parke writes that

> prevention should be based on the following assumption: All participants would benefit from the program regardless of whether or not they actually would have abused their children at some later date. Second, it is assumed that the program would reach a broad audience so that potential abusing as well as nonabusing individuals are exposed to the input. It is assumed that prevention should be conceptualized as an interrelated concept, which implies intervention at multiple levels: family, community, and culture.
>
> ### Prevention of Abuse: Family Level
>
> Prevention at the level of individual families can occur at a variety of time points and in a variety of forms. Two time points will be discussed: the high school period for targeting potential parents and the prepartum and early postpartum period for targeting new parents.
>
> In recent years, increased attention has focused on the preparenthood period as a time for intervention, on the assumption that it is easier to instill appropriate child-care skills in this period than modify already established parenting behaviors. A time when potential parents are universally accessible is during the teen-age high school period. Perhaps, it is time to heed Hawkins' (1971) call for universal parenthood training, which would be a part of the high school curriculum for all individuals--male and female. The Education for Parenthood program, which began in the early 1970s, is one positive response to this call. Alvy has recently described this program and spelled out the implications for prevention of abuse:
>
>> The Education for Parenthood program . . . strives to help teenage boys and girls prepare for effective parenthood through high-school-based educational experiences about child development and the role of parents, by participatory-observation experiences with young children in day care, nursery school, and kindergarten settings. This program has primary abuse prevention potential for several reasons. Its exposure of teenagers to the stages and processes of human development, both through classroom and field experiences, may influence the expectations of these future parents regarding children's emotional and cognitive capabilities at various stages of development. The exposure to child care workers who are sensitive to the needs of children, who are capable of

> appropriate channeling of aggression, and who are successful with children without having to use physical force creates excellent observational learning opportunities for these prospective parents.
>
> It is also possible that they will have learned to look for such guidance during early pregnancy or even before. "And perhaps most important, adolescents who have benefited from an Education for Parenthood course will be aware of the value and methods of family planning" (Cohen, 1973, p. 29) (Alvy, 1975, p. 925).

These types of courses are particularly important for males, as most adolescent males have much less contact with children than their female peers (through babysitting, etc.). Such courses would provide an opportunity for males to acquire caretaking skills and realistic expectations concerning parenting. However, attendance records show that a very low proportion of males take advantage of this opportunity for parent education. This suggests low motivation on the part of male students, and although mandatory attendance could provide for high accessibility, motivation would still be low.

Thus, during this period of preparenthood, males and females can be made accessible in large numbers for parent education, but do not appear motivated to learn parenting skills. This is not to argue against the existence of such programs, but to suggest that such programs may not be very effective as adolescents, especially males, probably see little relevance in learning parenting skills during this period and are thus not motivated to do so.

Perhaps preventive efforts would be more successful at a time when both accessibility to the target population and motivation to acquire parenting skills are both high. The period just after childbirth during the hospital lying-in period satisfies both of these criteria and therefore may be an excellent point for intervention. First, it is one of the few times when nearly all families are accessible. Second, it is a time when parents are likely to be highly motivated to receive information concerning child care and child development. Third, it permits the opportunity to provide corrective feedback to parents who can be directly observed interacting with their infants.

However, in contrast to our traditional focus on the mother-infant dyad, both mother and father should be included in these early hospital-based child-care orientation programs. The stress on both male and female is deliberate; as males are increasingly being urged to participate in infant and child care, support systems need to be made available for fathers to learn about parenting skills. Otherwise, we are only going to witness an increase in father-infant abuse, if males are forced to assume roles for which they are inadequately prepared (Parke, Hymel, Power, & Tinsley, 1980).

These programs should focus on not only the teaching of child care skills such as feeding and diapering, but on the development of play patterns, which in turn will enhance the value of the infant for the parent. Programs should also focus on teaching parents the general sequence of development that they should expect of their infants. This is particularly important in light of the overly high and unrealistic expectations of many abusing parents (Steele & Pollock, 1968).

Prevention of Abuse: Cultural and Community Levels

Continuing with the theme that child abuse is often the outgrowth of misinformation or ignorance about child care and child development, intervention can occur at both the cultural and community levels. At the cultural level, one of the most potentially powerful approaches to providing information concerning child care is television. It is nearly universally available in our culture, but to date, television has been relatively untapped for its potential in preventing child abuse by providing child-rearing education. Just as recent researchers have been developing short television spots on nonviolent ways of handling social conflict and on prosocial behavior for child viewers (Poulos, Rubinstein, & Liebert, 1975), the same type of techniques could be utilized for teaching parents appropriate child-care tactics and non-physically-punitive child-rearing disciplinary tactics. However, the use of television for modifying child-rearing methods is unlikely to be very effective without an accompanying decrease in the amount of violence in our television programs. In spite of fifteen years of data concerning the deleterious impact of viewing physical violence on television, there has been only limited progress in reducing the amount of violent programming. Finally, television could be used as a way of modifying our attitudes toward not only physical punishment, but toward children's rights as well. The issue of children's rights is complex and emotionally laden and television could serve as an important forum for education and discussion of this topic. In the final analysis, serious re-evaluation of this issue is a necessary step in attempting to decrease child abuse in our culture.

The implication of our earlier analyses, however, suggests that it is insufficient to focus only on child-rearing tactics. For either prevention or modification, the family must be viewed as a system embedded in a larger ecological network of community and societal systems. Modification of individual family interaction patterns alone is likely to be unsuccessful over a long period of time without recognizing the need for producing changes in the surrounding social network that serves to support and maintain the family's interaction patterns and that serves as a source of relief in times of acute stress. Long-term stability, as opposed to short-term modification of family-centered change, therefore, requires corresponding attempts to modify the family's access to and utilization of informal and formal social support systems. As Gil (1970, 1975), a consistent advocate of community-wide social changes as a solution to child abuse, has suggested, support services for mothers to relieve the stress of child care is of central importance. Gil's underlying assumption is that "no mother should be expected to care for her children around the clock 365 days a year" (1970, p. 147). His recommendations offer considerable promise for the control of child abuse. They not only may serve to relieve the stress of child-care responsibilities but also may provide an opportunity for the child to learn new rules of social interaction from peers and other adults.

At the neighborhood level, various strategies can increase contacts among families. Groups such as Parents Anonymous can reduce the social isolation of abusive families. Hot lines modeled after the suicide emergency telephone lines, provide a valuable immediate resource. Other efforts include the Block Mothers' Programs of St. Louis, Virginia Beach, and Des Moines, which are concerned about child abuse and runaways (Russell, 1975). Such programs could incorporate behavioral techniques aimed at modification of social isolation through modeling of social skills (see Bandura, 1977, Timm & Masters, 1974). Further, programs within the community can implicitly and explicitly present rules for child care that offer alternatives for family governance and facilitate understanding the needs and rights of parents and child (Belsky, 1980; Garbarino, 1981).

Finally, child abuse is not only a sociopsychological problem but a legal one as well. The police as well as the courts can play both preventive and treatment roles.

Although police are often the first formal authority to intervene in intrafamily conflict, little attention has been paid to their role in the prevention and control of child abuse and family violence. Parnas (1967) estimated that more police calls involve family conflict than all other types of criminal incidents. Police intervention often occurs before conflict has escalated to the abusive level, while medical authorities typically encounter the family only after the abusive incident.

Bard's work provides evidence that police can function effectively in settling intrafamily disputes and thereby may prevent the escalation of violence to abusive levels. A special "Family Crisis Unit" was trained to handle family disputes through such techniques as modeling, role playing, lectures, and discussion groups. Bard noted that, although "40% of injuries sustained by police occur when they are intervening in family disputes . . . the 18-man unit, exposed for more than would ordinarily be the case to this dangerous event, sustained only one minor injury" (1971, p. 152) during the two-year project. The use of nonphysical tactics in interventions in family disputes, such as advice and mediation, not only defuses a short-term problem but also serves as a model of alternative ways of settling conflict. In sum, Bard's project shows that professionals within the legal system can effectively serve as facilitators of more constructive family functioning rather than merely as agents of law enforcement.

The courts can play a variety of constructive roles. For example, the legal system can redefine the rights of children through legal decisions. However, the recent Supreme Court decision (Ingraham versus Wright), which sanctioned the rights of school authorities to physically punish children (Zigler, 1977), suggests that legal reassessment of children's rights is not likely to come about soon through the courts. However, the legal system can serve as an authoritative partner in the process of resocializing child abusers by 1) making parents aware of available social services and 2) facilitating and enforcing parental participation in therapeutic programs established by other community agencies. (For fuller discussion of these issues, see Newberger & Bourne, 1978; Parke, 1977; Rodham, 1973).

In summary, prevention needs to be a multilevel effort in which the interrelationships across the familial, community, and cultural levels are recognized. Our telescope model of abuse has provided one approach that can serve as a guide for our prevention efforts. In the final analysis, by focusing on prevention, prediction may be an unnecessary goal.

MANAGEMENT

In "Prevention in Child Welfare: A Framework for Management and Practice" by Sundel & Homan, a framework of secondary prevention as early intervention is considered, and tertiary prevention as treatment and rehabilitation. The goal of primary prevention includes both the amelioration of environmental conditions related to problems, and the promotion of social and emotional well-being.

Implications for Management and Practice

Program and management analysts recognize that the manner in which problems are stated can significantly affect the structure, implementation and evaluation of social programs. A complete problem statement should include, at minimum, information on: target population; description of the problem and its magnitude;

hypothesized cause or causes; alternative programs and services to meet the problem; and proposed measures of outcome or impact.

A description of the target population should include information on age, sex, ethnicity, socioeconomic status and geographic location. The vulnerability of the population to the specific problem should also be described.

Measures of problem magnitude are essential for development of a comprehensive child welfare service delivery system. Problem magnitude has been described in public health terms as incidence and prevalence. Incidence, referring to the number of new cases within a given period, provides information that can be used to measure the impact of primary preventive services. Prevalence, referring to the total number of cases at a specific time, provides information that can be used to measure the impact of early intervention and treatment and rehabilitation services.

The issue of causality is important to program planners interested in prevention. Although opponents of prevention have often cited the dearth of data on the causes of social problems, Rapoport suggested: "The preoccupation with tracking down a causative agent is far from fruitful or even necessary when dealing with a multifactorial system. It is more useful, therefore, to understand the interrelated parts of the complex system and to plan strategy which could interrupt, at any one of several points, factors contributing to the development of pathology" (16:7). An important implication is that a variety of services should be available to address the diverse factors frequently associated with a social problem such as child abuse or neglect.

COMMUNITY APPROACH

The last article included in the design section is "Stopping Abuse Before It Occurs: Different Solutions for Different Population Groups" by Anne Harris Cohn. This paper came about as a report on a conference that reviewed the literature in regard to cultural and ethnic differences among population groups. The participants called for each community to structure a prevention program to suit its own needs. The article also reviewed the efficacy of various kinds of prevention programs (which will be discussed in the Criteria Section); however, first the author outlines the existing prevention programs:

> Child abuse is a community problem and its prevention is a community responsibility. The community must provide parents and children with certain supports, training and information to help them cope successfully with their roles in the family. The community approaches must reflect the unique attributes, values, and general disposition of a given community or population group.

At the same time, the types of approaches which need to be present in any community can be described rather generically.

While research seems to suggest that the earlier support can be provided to families the better, the experts acknowledge that for child abuse to be prevented, families need support at many different times. Thus, a variety of prevention programs, directed toward each phase of the life cycle, beginning with the prenatal period and continuing through a child's school years, seem essential if child abuse is to be reduced. These programs include:

--Perinatal support programs--to prepare individuals for the job of parenting and to enhance parent-child bonding.
--Education for parents--to provide parents with information about child development and skills in caring for children.
--Early and periodic childhood screening and treatment programs--to identify physical and developmental problems in children at any early age and to correct them.
--Programs for abused children--to break the cycle of abuse.
--Social skills training for children and young adults--to equip children and young adults with skills and knowledge necessary to succeed in adulthood.
--Mutual aid programs and neighborhood support groups--to reduce the social isolation so often associated with abuse.
--Family support services, including health care, family planning, child care, crisis care such as hotline counselors, marriage counseling and related services--to provide families with the range of supports which they need to survive the stresses of life and to stay together.
--Public information about child abuse--to heighten the public's awareness about different types of abuse and neglect and to provide specific information on how they can be prevented.
--Community development activities--to increase local opportunities for job training, employment, access to social and health services, and other supports which reduce family stress.

Taken together, these programs comprise a comprehensive community approach to preventing child abuse. To help ensure efficient and appropriate implementation of these programs in any community, certain support activities seem to be necessary, including:

--Community organization
--Coordination among community agencies
--Child and family advocacy
--Ongoing evaluation and assessment
--Child abuse prevention training

A community-wide child abuse coordinating council or coalition has been, for many communities, an effect approach to ensuring that the above activities are pursued.

Program Design

Perinatal support programs. The purpose of perinatal support programs is to prepare individuals for the job of parenting. Such programs should include supports during both the pre- and postnatal periods. Prenatal programs can build on existing medical programs and educate about-to-be parents in child development, parent-child relationships, and adult relationships. Information on community resources available to new parents and to infants and children should be provided. By supplying information and by teaching skills for coping with the challenges of being a parent, special emphasis should be placed on developing techniques useful in communicating with the new baby. One focus of these services should be to develop group activities that form a social network among new parents, thereby creating peer relations and peer support. Although such programs should be available to all parents, special attention should be paid to first-time parents, teenage parents, and single parents.

Prenatal and postnatal medical care is clearly important, particularly since low-birth-weight babies and babies otherwise sick in infancy are at risk for being abused. Many prospective parents now participate in prenatal care programs that go beyond th medical needs of the pregnant mother and the growing fetus to include attention to the demands of parenting. All prenatal care programs should provide prospective parents with parenting education and other supports to ease the difficulties associated with having a new infant in the home.

Some studies suggest that in families in which parent-child bonding is weak the child is at greater risk for abuse. Part of the function of perinatal support programs should, therefore, be to enhance parent-child bonding. Childbirth procedures involving both parents or some supportive person, rooming-in, and unlimited visiting privileges for parents with their infants are important in lessening the length and complications of labor for the mother and the child and the likelihood of abuse for a year after birth. Minor changes in hospital procedures should facilitate opportunities for families to get to know their newest member, while enhancing the possibilities for early and effective parent-child bonding. Even though some studies show that early contact ("bonding") does not directly prevent child abuse, early contact seems in any case to be high. Many hospitals offer prospective parents the opportunity to participate in programs that enhance the bonding process. All hospitals should offer such options.

As a continuation of the prenatal program and as part of perinatal support programs, all new parents should have an opportunity to participate in a program to increase their skills in caring for a new baby. The program should be directed toward the creation of social networks, through new-parent groups or by pairing first-time parents with experienced parents, and toward the continuation of instruction in child care and child development. Information provided during the perinatal period and early childhood seems crucial; information provided too early seems of little value.

Such a program should also offer well-baby and well-parent health and development checkups at regular intervals after the family leaves the hospital. These checkups can become the first activity of the home visitor program. While the home health visitor program has not been well researched, successes have been documented. Many hospitals and group medical practices currently offer such services to new parents, and they should be available to all new parents.

Having a new infant in the home creates stress in any family. When, however, the infant requires extra or special care, stress can be greatly increased, putting the child at greater risk for abuse. To reduce the additional stresses created for parents by infants with special problems following birth--for example, premature babies or those with illnesses, abnormalities, or defects--a special perinatal support program should be available. The program should focus on group support from parents with similar children, and it should educate parents about the particular needs of their child and how to deal with those needs in a family environment. Every attempt should be made to furnish supports that minimize distortion of the parent's perception of their new child. Separating newborn babies from their families to provide intensive care can require special adjustments for parents, and they should receive help that is sensitive to this unique stress.

Among the problems experienced by families with young children is isolation from and lack of knowledge about health and social services in the community. Coupled with a lack of knowledge of how to detect and handle many childhood problems, this puts a family at risk for abuse. As an ongoing source of support and information for parents, perinatal support programs should include home visitor services that consist of periodic visits to the home following childbirth until the child begins school.

These visits should be made by a trained home health aide under the supervision of medical professionals. The aide should provide information and advice to parents on child care, nutrition, and home management and should carry out routine health checkups on young children. In addition, the aide should refer parents to needed social and health services in the community. In some communities the services of the home visitor can be effectively rendered through a local well-baby program.

While perinatal programs seem well advised for all population groups, the process or method of providing information or support should undoubtedly vary from one population group to another. In addition, while there will be interrelationships or spill over benefits from a perinatal program designed to present one type of abuse or neglect into other areas of maltreatment, the educational and informational portions of perinatal programs clearly can and often do target on certain types of maltreatment.

Education for parents. Education for parents is essential to ensure that children's primary caretakers have information about child development as well as skills in caring for children. Education for parenting is an ongoing process that continues throughout one's life and is secured in a variety of ways. From one's own parents, parenting skills evolve; the more this source of education and skill development can be strengthened, the better. Various experiences throughout childhood and the schooling years provide individuals with additional information about and insights into child development, child care and parenting more generally. However, opportunities for such informal education and skill development have lessened as extended families diminish, family sizes shrink and individual households find themselves increasingly isolated from their neighbors and relatives.

The purpose of education-for-parents program is to provide to parents that information about child development and child care and those skills related to parenting which parents need to fill a parenting role and which parents might not have received elsewhere. Such programs may be provided through educational and medical institutions as well as through local community civic or religious organizations. The structure and content of such programs will vary considerably depending upon the age or particular problems of the children concerned as well as other ethnic and cultural considerations. Parent education programs will of necessity vary in content depending upon the type of abuse one is interested in preventing.

There are many recognized parent education programs across the country. Success or effectiveness of such programs is related to: provision of such education early in the parenting period; provision of such education over a long period of time, and using multiple approaches to the provision of such education.

Early and periodic childhood screening and treatment programs. Because of the roots of abusive behavior, many health and developmental problems in childhood can lead to behavioral problems in adulthood, including abusive behavior. In addition, many health and developmental problems in childhood may be symptomatic of abuse or neglect which a child is sustaining or minimally of difficulties children are sustaining within their own families. For these reasons detecting and treating health and developmental problems early in life is important. Early childhood screening and treatment programs should be seen as a continuation of the preschool screening services, such as those offered by the home visitor. The purpose of such programs should be to detect problems school-age children may be having, including abuse and neglect, and to ensure that these children receive the necessary health, mental health, and other services that will best protect them from becoming abusive parents.

Screening and treatment programs exist throughout the country in preschools and schools; they should be available to all children. Follow up treatment is an essential part of any screening program, as this is the assurance that children's problems are remediated. All screening programs, however, need to be sensitive to the possibility that a child may be inappropriately labeled, with long-term negative consequences. Screening programs should be comprehensive enough to detect all forms of abuse and neglect. While the choice of location, timing and provider of screening services may need to vary somewhat from one community or cultural or ethnic group to another, in general screening programs can be standard across population groups. Follow up and subsequent treatment may well have to depend upon the population group or type of problem being tended to.

Programs for abused children. It has been argued that prevention of abuse is in part tied to providing therapeutic treatment to children or young people who have been abused or neglected. To minimize the long-term effects of abuse, age-appropriate treatment services should be available to all maltreated children.

Treatment programs for abused children should include a thorough diagnosis of physical and developmental (social, psychological, and emotional) problems. Comprehensive therapeutic services should be offered to alleviate identified problems. Assistance should be rendered on the basis of an individual child's needs and should include individual and group services as well as an enriched day care program. Interaction of the child with his or her family is a critical part of any child treatment program.

While those public agencies responsible for investigating cases of alleged child abuse and neglect may well bear the responsibility of ensuring that abused children are referred on to therapeutic treatment, treatment programs for abused children may be the responsibility of medical and education institutions as well as various local, community civic or service organizations.

In general, since children's programs need to be structured to accommodate an individual child's needs, cultural, ethnic and community issues should by definition be accounted for. Although treatment strategies for children who have been sexually abused may be somewhat unique, in general the treatment needs to be oriented more toward the kinds of emotional, social and developmental problems the child sustains rather than the actual type of abuse or neglect perpetrated against the child.

Social Skills Training for Children and Young Adults

The purpose of social skills training is to equip children, adolescents, and young adults with interpersonal skills and knowledge that are valuable in adulthood, especially in the parenting role. Knowledge and skills can be imparted in a variety of ways; irrespective of the specific techniques, educational classes or supports should be provided throughout all grades in the school system to provide young people with that which is necessary to make one's way in the world in an interpersonal sense, e.g., an ability to relate to people effectively.

Skill and knowledge building should be stressed in areas of family and life management, self-development, self-actualization, and methods of seeking help. For adolescents in particular, education in sexuality, pregnancy prevention, and issues related to parenting should be provided.

Such social skill training is seen as essential to the prevention of all forms of abuse and neglect, regardless of community base or population groups.

Mutual aid programs and neighborhood support groups. Social isolation, not having anyone to turn to in times of need, plagues most families who are at high risk for abuse and neglect. The purpose of mutual aid programs or neighborhood support groups is to reduce the isolation experienced by many parents through the development of peer support systems.

Beginning with social networks created through parent groups in the prenatal and perinatal programs, a variety of opportunities should be offered for parents to participate in group activities or to establish social contacts. Examples include parent groups stemming from local child care programs, Foster Grandparents Programs, Parents Anonymous, and comparable problem-oriented self-help or support groups. The mutual aid programs can also focus on the development or strengthening of neighborhood-based natural helping networks.

Social networks or social support groups can help to reduce insularity and isolation, while providing nurturance and feedback. Sufficient studies have been completed to suggest the efficacy of such approaches for the prevention of all types of child abuse as well as a variety of other social problems. However, because isolation means different things for different population groups, because the nature and function of social networks varies across communities and population groups, cultural, ethnic and geographic issues must be taken into account as communities seek to develop mutual aids and support groups.

Family support services including health care, family planning, child care, and crisis care. The purpose of family support services is to ensure that all families have access to the range of supports which they need to survive the stresses of life and to stay together. Families unable to cope with the stresses of life are all too often those in which abuse occurs. Certain supports could be made readily available to all to help dissipate certain life stress.

Because poor mental and physical health creates stresses within a family often associated with abusive or neglectful behavior, medical and mental health care should be easily available and accessible to all families, particularly maternal and child health care.

Family size, spacing of children and numbers of children are significant factors in understanding child abuse. Family planning services should be readily available to all, particularly adolescents and parents having difficulties with their children.

Child care or day care programs furnish parents with regular or occasional out-of-home care for their children. While child care is a necessity in households in which all adults are employed, such services are also beneficial for parents who do not work outside the home but who find continuous child care responsibilities very stressful. Child care programs also provide opportunities for children to learn basic social skills. Head Start programs in particular provide a rich mix of child care and child development services.

Lacking anywhere to turn in times of crisis puts families at significantly greater risk for abuse or neglect. To provide immediate assistance to parents in times of stress, crisis care programs should be available on a 24-hour basis and should include the following services: telephone hot line, crisis caretakers, crisis baby-sitters, crisis nurseries, and crisis counseling. Through these programs, parents facing immediate problems could receive immediate support to alleviate the stresses of a particular situation. Help should be available over the phone or through in-person counseling.

The programs should also offer parents the option of having someone come into their homes on a temporary basis to assist with child and home care or of taking the child to a crisis nursery. Because crisis care is temporary and short-term, such programs should be equipped to refer parents to long-term services as needed.

Crisis services as well as child care services, need to be sensitive to cultural and ethnic issues; crisis programs, for example, may simply appeal more to certain population groups and therefore be more effective for certain groups.

Public information about child abuse. The basis of any efforts to prevent child abuse is understanding what the problem is and where and how to reach out for help. Providing information to the public through the media in a variety of ways is essential.

One method of information dissemination is public awareness campaigns. TV, and radio spots, print media ads, bill boards and transit posters are usual methods for such campaigns. Public awareness campaigns have three complementary purposes. The first is to bring parents the message that being a parent is not easy, that all parents experience stress in the parenting role, and that it is all right to reach out for help. The second purpose is to provide parents with information about where to turn for help, particularly how to get in touch with local crisis care services. And the third is to give a value message concerning the worth of children in our society (e.g. that children are our greatest resource). Depending upon the type of abuse or neglect one is attempting to prevent, the messages in such campaigns must vary. Clearly cultural and ethnic issues as they pertain to language are of relevance in communicating messages.

Another method of information dissemination, is through the use of the dramatic arts. Plays, films, video tapes, and the like shown at schools, local events, shopping centers and other public places can be used to sensitize audiences to specific aspects of abuse and neglect and their prevention.

Community development activities. Community development activities, which include economic development, job training, access to health and mental health services, have as the primary purpose the development supports which reduce general community stress. Studies suggest that as unemployment rates rise, so too do violence rates. As individuals are cut off from the goods and services of society, violence rates increase. In order to increase overall community well being, thereby diminishing stress associated with violence--including child abuse--community development activities are included as part of a prevention plan.

It has been the experience of those concerned with prevention efforts that concepts of prevention can only be as successful as the community wants them to be. Getting community intellectual support is only half the battle; getting community involvement and participation in the planning and doing has been more difficult.

There is scant empirical analysis of organizational and other contextual factors that foster or discourage provision of prevention services. Descriptive studies of prevention services offered in community mental health and health settings suggest that provision of such services is minimal in many settings and that primary prevention directed toward modifying basic social and environmental factors is the least common type of prevention offered. Consequently it is impossible to find a specific step by step approach for enlisting community support for prevention programs. That is because each community is so individual that one's how to method might not be applicable to another. However, there are some general considerations that should be remembered when one is determining a community's characteristics and resources for supporting a child abuse and neglect prevention program.

Obstacles to Prevention Services

Nance (1982) categorizes resistance to prevention into three areas: 1) the state of knowledge about primary prevention and about intervention in general; 2) public values; and 3) the values of and traditions in the helping professions. Miller (1981) also mentions many of the same obstacles. In Nance's first category is included the concerns regarding the lack of clarity about the term "primary prevention" and that it means different kinds of services to different professionals. However, more agreement has been reached in this area in the last couple of years, at least in the literature. Other problems cited by Nance are:

--problems related to establishing cause and effect and the complex nature of the world, more specifically the establishment of links between cause and effect based on the public health model of finding a cause for a problem and then treating the cause

--lack of models for building a framework which makes it difficult to explore possibilities for services and make comparisons

--this is particularly so on the macro level or societal level which means there are few concepts on which to build primary prevention for the general population

--lack of knowledge about how to intervene effectively in complex situations, i.e., poorly developed or inappropriate research technology

--transferability: the feasibility of what works in one setting also working in another; even if a significant causal link between primary prevention approaches and a particular end result is discovered, there is no reason to believe that the link will be permanent over time

--historic lack of experience with primary prevention

--inability of the social sciences to demonstrate their effectiveness.

All of these factors effect the power of the expert or the professional to persuade a community or an organization that prevention really works or that specific preventive approaches are effective.

In the second area of public values both Nance and, in her own list of obstacles, Miller cite the traditional separation of government and families and the degree of stigma attached to receiving social services:

--citizens' right to privacy

--the crisis orientation of society in that we respond only after we recognize a problem, and the nature of primary prevention involves long-range planning

--fear of change

--fragmented constituency: there is no active, unified constituency pushing for family concerns and a preventive focus; while the voluntary sector is a powerful lobbying force, important conflicts of interest exist within it.

These points involve important issues of individual choice, power, and assumptions about human nature.

In the third area of values and traditions of professionals in social work is the fear that primary prevention will drain resources away from treatment and rehabilitation efforts. This is the reason that social work and public health professionals officially moved away from prevention services in the 1960's.

In addition to defining the problems for gaining community and organizational support for prevention services, the literature also provides some positive suggestions for working with communities in the promotion of preventive services. Prior to discussing how the information might be helpful to specific program planning, the useful material from the literature will be summarized in the following sections.

Strategies for Promoting Primary Prevention (Nance, 1982)

Reducing the threat of primary prevention for those who might fear its change or distrust its effectiveness involves dispelling the myths about primary prevention (or reducing their impact) and linking prevention with familiar, accepted modes of intervention. It involves examining which components of primary prevention are most threatening. For example, look at the issue of sociopolitical values and avoid those techniques of change that threaten individual freedom. Doing so involves a conscious choice about what issues to address and what not to address. The idea of avoiding areas in which barriers to change are particularly resistant also can be applied to who should be targeted for change. For example, the amount of power that people have is an important variable in determining whether they will tolerate intervention. Thus, making the intervention voluntary is one alternative. Another alternative is to focus the intervention on persons without much power who, therefore, will not pose significant resistance. Examples of these two alternatives are: 1) to offer special benefits to people who take parenting classes, just like insurance rates are reduced for those who take defensive driving courses; or, 2) to require all mothers and fathers who receive welfare to take parent education classes.

The degree of personal involvement has a lot to do with whether intervention is acceptable. Therefore, keeping intervention on a personal level is another strategy for developing primary prevention programs. A related strategy is to focus on intervention techniques and topics of concern that are already familiar to professionals.

Designing programs to reduce resistance by eliminating the most threatening components has some disadvantages. It implies incremental change and having an impact on small number of people.

Organizational Characteristics Which Promote Prevention Services

Jansson (1982) did a survey of 163 social agencies to come up with a set of variables associated with an emphasis on prevention:

--agencies that assist people before they develop serious problems must use outreach to find and draw people into programs

--considerable planning is required in preventive programs to count, locate, and provide outreach and service to such populations at risk; if the staff has not had experience in planning or does not have planning skills, prevention activities will be difficult for them

--many agencies that provide curative services do not need to establish close links with outside agencies; those emphasizing prevention must negotiate service arrangements with schools, police, hospitals, and other organizations that have access to consumers who might benefit from their services

--prevention services are implemented and funded only when they are favored and promoted by those with influence and power and only when they are perceived to increase organizational resources in an uncertain environment

--if an agency is not committed to non-traditional services, it is unlikely that it will provide prevention

--in regard to work settings, prevention is likely only if it is emphasized in agency policies and procedures such as hiring and promotion policies, staff meetings and staff training

--in regard to the interplay between an organization's tasks and its characteristics, certain kinds of procedures and norms develop within organizations as they are required to facilitate the organization's tasks. An agency that has relatively simple tasks (for example, checking consumer eligibility for food stamps) often develops traditional bureaucratic features because these facilitate implementation of relatively routine tasks. Staff in such organizations are often given little autonomy and follow routine procedures. By contrast, organizations that provide more complex services often evolve more fluid organizational arrangements. Thus, agencies that develop innovative services often give staff more autonomy in their work and involve them in planning projects to facilitate new services.

Tailoring Prevention Services to Individual Communities

> "Workers should regard their activities as empowerment of the program's participants and foster community ownership rather than dependence. In addition, this high degree of participant involvement is truly democratic and this very process itself, more so than contrived exercises, facilitates emotional and cognitive integration of the developmental skills. This implies that prevention programs cannot be 'canned' packages which claim to validate 'reinventing the wheel.' Rather they develop slowly fostering mutual interchange, disagreement, and negotiation, and are significantly shaped by the ethnic, cultural, and personal values of those who participate. In a paradoxical way _the leader follows the group_ in such a program" (Williams, 1980).

Systemic

A systems approach enables the workers to conceive of the target population as one subsystem within a larger support system (such as the children in an elementary school). The major support system through which the process is initiated and which assumes ownership of the program can be identified as the "receiver system," or in Havelocks' (1973) term the "user system" (such as a school, church, hospital, community organization, or a combination of these). It is a group in which the target population is already functioning and obtaining meaningful rewards.

Relevant subsystems within the receiver system will be involved in the planning (such as administrators, support staff, clinical staff, teachers, families) and the way they interact will have critical impact on the program.

System properties that should be noted by workers are:

1) Commitment: full cooperation is required
2) Authority: sharing of goal-setting and decision-making at all levels
3) Division of labor: must be a clear delineation of goals and tasks, and the roles and responsibilities to be assumed by participants
4) Emotional atmosphere: trust and openness in communication
5) Conflict resolution: acceptance and valuing of individual participants' ideas strong enough to motivate the tedious process of synthesizing divergent views and values
6) Ownership: receiver systems must demonstrate internal acceptance of program's goals and processes; a clear indicator is "hard" money. Change will come, but come slowly and should be constructively built into the program.

Collaborative

Neither the provider nor the receiver (support) system exists in isolation. Each exists in a community and has numerous ties. Because resources are limited various organizations regard themselves as competitors rather than as collaborators. This often results in fragmentation of services, wasted resources, and less than adequate services to the community.

However, the goals of collaboration are to conserve limited resources, to achieve the highest possible quality in programming and to make the process relevant to the life experience of the receivers.

> "This process of securing the commitment, support, and new learning of so many people in different organizations which are already experiencing substantial demands on their limited resources should be seen by providers and receivers alike as the prevention process. Through it the holders of social and political power are called on to develop and practice the very skills and attitudes they seek to impart to their 'target' population. This process is clearly a political activity as well as an educational one (Albee, 1980). In this sense, wellness and prevention programming must be seen as a dynamic, collaborative and democratic process of individuals and community systems of all kinds and levels. It is the kind of activity that Rogers (1977) refers to as a new, person-centered political revolution."

Working with Professionals in the Community

The following section provides information on different professionals' views of the causes of child abuse. It might be helpful in working in the community to realize that different groups have different ideas about child abuse and neglect.

Gelles (in Starr, 1982) reported on a study of professionals and their ideas about the causes of child abuse and neglect. The following gives a summary of the chapter.

Causes of Child Abuse

> In order to determine the factors professionals viewed as the causes of child abuse, we presented them with the following list of fourteen items that could be viewed as causes of child abuse.
>
> 1. Maturity of parent or parents
> 2. Whether child was wanted by parent or parents
> 3. Drinking (alcohol)
> 4. Family financial status
> 5. Personality disorder of parent or parents
> 6. Unemployment of father
> 7. Parent's expectations for the child
> 8. Parent(s) abused as child
> 9. Child's behavior
> 10. Isolation from relatives or other friends
> 11. Drug usage by parents
> 12. Stress on family
> 13. Single parent family
> 14. Social class of family
>
> Each respondent was asked to rate each item in terms of how strongly the item was causally related to child abuse (0 = unrelated; 1 = weakly related; 2 = somewhat related; 3 = strongly related). The most important and least important causes of child abuse were ascertained by averaging the responses for each item. Thus, the higher the average score, the stronger the imputed relationship between the item and child abuse. The closer the average was to zero, the more unimportant the factor was as a cause of child abuse.
>
> ### Causes: "Kinds of People"
>
> Examining the entire sample of professionals, we find that child abuse is generally viewed as a problem caused by particular people with certain personal or personality problems. The respondents as a whole felt that personality disorders were the most important cause of child abuse (a mean rank of 2.69). Drinking was

considered the second strongest causal factor (2.64). The third ranked factor was the maturity of the parents (2.46).

Thus, the three items listed as the most strongly related causal factors were items that dealt with intra-individual problems of individual caretakers. It is clear that the professionals viewed child abuse as caused by individual pathology or problems.

Less important factors included whether the child was wanted by the parents (2.39), whether the parent was abused as a child (2.34), and drug usage (2.29). It is not until the seventh most important item that a social-situational factor, stress on the family (2.26), is considered. Other social-structural conditions such as family finances (1.50), father's unemployment (1.47), and isolation (1.52) are believed to be more weakly related to child abuse than personality or other individual factors.

The factors that were considered largely unrelated by most professionals are single parent families (1.23) and social class (1.07).

Physicians

Physicians who were surveyed tend to view child abuse as caused by the personality problems of individual caretakers. The item rated as the most strongly related to child abuse was personality disorders. Drinking and maturity of the caretaker were rated as the next most important causes. Physicians viewed social class and single parent family as only weakly related factors.

The physicians' selection of personality and other intra-individual factors as variables strongly related to child abuse, and their rating of social factors as being only weakly related is consistent with the medical profession's approach to this issue as revealed in published articles on child abuse by medical practitioners. Physicians, as a result of their training, tend to approach child abuse with a medical mode of causation--viewing child abuse as caused by some pathology within the individual caretaker. The existence of the medical model approach is reflected in our research by the findings that physicians chose intra-individual factors and kind-of-person items as the most significant causes of child abuse.

Emergency Room Physicians

Physicians employed on a full-time basis in the emergency rooms of public and private hospitals had a view of the causes of child abuse that was quite different from their colleagues who were in private practice or full-time staff members of hospitals. The emergency room physicians saw unwanted children as being the most strongly related cause of child abuse. Personality disorders, drinking, and caretaker maturity were rated lower as causal factors by emergency room doctors than by their colleagues who practiced less crisis-oriented medicine. Another interesting difference was that physicians as a group saw the child's behavior as a stronger correlate with abuse than did emergency room physicians (physicians' mean was 1.79; emergency room physicians' mean was 1.33). Other interesting differences were that social psychological variables such as social class and single parent family were rated as slightly more important causal factors by emergency room physicians than by physicians in general.

Given that emergency room and other physicians tend to have similar backgrounds in terms of training and socialization into the medical model paradigm, how is it that they differ in their view of the causes of child abuse? We hypothesize that the differences are due to varying experience with cases of child abuse and the actual encounters the physicians have had with abused children and their families. Emergency room physicians may well have had much more contact with abused children. This contact might have afforded them more insight into the social-psychological dynamics of the families of abused children than their colleagues in general practice. For example, emergency room physicians' experience with abused children might have provided them with insights into whether the child was "wanted" by viewing the behavior of the parents in the emergency room. Similarly, the fact that emergency room physicians actually see the consequences of abuse, might lead them to conclude that the child could not have provoked such an assault (thus, the lower rating of "child's behavior" by the emergency room doctors).

In summary, experience with actual child abuse cases and the number of cases actually seen may have produced the different evaluations of the causes of abuse by members of the same profession.

Elementary School Counselors

Elementary school guidance counselors rated personality disorders as the strongest causal link with child abuse and their mean rating of this item (2.88) was higher than the mean of any other professional group.

Although counselors viewed personality problems as the most important cause of child abuse, they displayed sensitivity to social and environmental factors. The factor ranked second as a cause of child abuse was "parent abused as child." Stress was viewed as a more important causal factor by counselors than by physicians, emergency room physicians, or principals. At the other end of the continuum, social class was considered almost totally unrelated to child abuse (.79).

It is interesting that counselors, one of the professional groups with the least contact with abusive parents, would rank "parent abused as a child" as such an important factor. Given that counselors have such limited contact with abusive parents, we might postulate that their attitudes toward the "vicious cycle of child abuse" are a result of their reading of the literature on this topic or a consequence of their professional training, which may include contact with social learning theory.

Principals

Principals displayed one of the more striking variations in their analysis of the causes of child abuse. They rated drinking as the prime cause of abuse. They also rated drugs as a more significant causal variable than did any other professional group. The other factors identified as important causal factors indicated that principals tended to see the root causes of child abuse as stemming from intra-individual pathologies or weaknesses.

Why principals were prone to view abuse as a result of alcohol or drug problems is interesting. There would appear to be nothing in their training or experience that would produce a view of child abuse as being caused by a chemical that causes a parent to lose control. Since principals are a professional group that probably encounters child abuse rarely, if at all, and since the educational and occupational training principals receive typically does not include any information on child abuse, the choice of drugs and alcohol as causal factors may reflect the fact that principals employ a "common sense" view of child abuse, which includes the assumption that abuse is caused by a parent or caretaker "losing" control.

Social Workers: Public and Private

Social workers employed in public and private agencies shared the same causal paradigm of child abuse, which showed a high degree of sensitivity to both social and psychological causes. Social workers listed "parent abused a child" as the strongest correlate with child abuse. Personality disorders was ranked second, while the third most important item was stress. Social workers were the only professional group that ranked stress as one of the three most important causes of child abuse.

Social class and isolation were rated last by social workers, but even in this ranking, the mean importance imputed to these items was higher for social workers than for other professional groups.

The consideration of both social and psychological factors as important causes of child abuse would appear to be a reflection of the model of causation taught to social workers and employed in their work. Unlike the medical model employed by physicians or the common sense model employed by principals, the social work paradigm includes an awareness and sensitivity to causes that exert pressures on people as well as forces that arise within the individual.

Police Officers

Police officers, like emergency room physicians, tend to encounter cases of child abuse in the crisis stage. This experience may well color their causal assessment of child abuse and explain why emergency room physicians and police officers had similar views of the causes of abuse.

Police rated drinking as the factor most strongly related to child abuse. The second strongest relationship was thought to be between unwanted children and abuse. Personality disorders and drugs were listed as the next most important causes.

We would hypothesize that drinking and drugs were rated as important causal factors because police tend to employ the common sense perspective that argues for elements that cause people to lose control as being important causes of child abuse. In addition, police, who are called upon to intervene in family disputes, tend to build a normal picture of family disputes and violence as arising from drinking and drug problems.

Summary

There is a rather clear indication that, in most cases, the causal patterns identified by professionals are quite different than the causal patterns of child abuse discussed in the scientific literature. Thus, we can hypothesize that for our population, views of the causes of child abuse were not developed from reading the literature; or, if they read the literature, they did not fully believe it. It appears that the causal "models" of child abuse held by most professional groups is a consequence of their professional training and the extent of and nature of their contact with abused children and abusive caretakers.

Economic Considerations

There has been very little written about the economic aspects of prevention services, and research studies and program descriptions rarely include budgets. However, there is some general information regarding cost-benefit analysis and the problems in constructing one based on prevention. There is also some information on the most expensive kinds of programs as well as eligibility requirements for services.

Eligibility Requirements

The establishment of eligibility criteria works contrary to the principle of preventive service. If one must manifest the problem characteristics before being eligible for service, how can services be provided to prevent that very manifestation? Diagnoses or eligibility determinations are required to justify prescribed services. Although this requirement could result in premature diagnosis of a situation as pathological, it may be undesirable to defer services until a situation has been thoroughly investigated. Delay can result in clarification of the situation. This clarification, however, often stems from further deterioration in the environment of the client. The problem of such delay is illustrated by the number of children placed in foster care before any services were offered to prevent the placement.

Although the legislative language of programs purports to support preventive efforts, in practice attention to "at risk" groups is discouraged if prior behavior has not been sufficiently dysfunctional. Reimbursement that is contingent on following strict eligibility guidelines serves as a disincentive to preventive efforts and results in a disturbing paradox. Only if and when a parent abuses or neglects a child is either entitled to the services that might have prevented neglect or abuse had they been available earlier (Miller, 1981).

Expensive Services

Of all the realm of available services, from self-help groups to family therapy, there is some indication that family therapy is the most expensive:

> Intervention strategies based on counseling or therapy for families and behavior modification programs are expensive in time, personnel, money and there is question as to how long the change in the families lasts (Cohen, Gray, & Wald, 1984).

The main goal of prevention services would be to reduce the cases of child abuse and neglect; however, Sundel and Homan (1979) note another important savings resulting from prevention services:

> An effective child welfare services delivery system should ultimately reduce the active caseload of clients with severe problems (and the recidivism rate), with an accompanying increase in the number

of children and families receiving primary preventive and early intervention services. This objective is consistent with the public health model goal of reduction of cases in the tertiary stage. Although few analyses of the costs of services to child welfare cases of varying severity have been conducted, the cost implications of overall reduction of the severity of cases could be important. Over the long run, increased primary preventive activity might reduce the cost of serving cases in an advanced stage of problem development.

The cost effectiveness of prevention services has hardly been explored at all. Neither has the goal of reducing incidence of child abuse and neglect.

Reasons:

Methodological: problem of definition; funding mechanisms are nearly impossible to link to particular clients or outcomes and external effects are difficult to control; inability to estimate true costs and benefits.

Psychological: historically, social services have not done well in impact studies; some studies have damaged the reputation of casework; child abuse and neglect treatment programs have demonstrated mixed success in attempts to rehabilitate families.

Cost Benefit Analysis

Despite the difficulties noted above, Martin Bloom in his book *Primary Prevention: The Possible Science* attempts to outline a cost benefit analysis for prevention services.

A General Formulation of Costs and Benefits in Mental Health

The following formula is actually composed of two separate cost-benefit ratios, but they might be more appropriately viewed in tandem to recognize the systemic elements involved. It is a very general formula, and below, its components will be discussed.

$$\frac{\text{(A) Costs in supplying preventive services per unit served} \qquad \text{(B) Unit benefits derived from prevention}}{\text{(C) Costs in supplying treatment and rehabilitative services per unit served} \qquad \text{(D) Unit benefits derived from treatment and rehabilitation}} = \text{A cost-benefit ratio of helping}$$

First examine the components of preventive costs (A). There are costs to the preventive organization in terms of personnel, administration, equipment, and other miscellaneous expenses found on any budget form. A second category not usually found in conventional accounting forms is costs to recipients of the preventive services, such as income lost from being away from productive labors, if any, as well as expenses, such as transportation incurred in participating. A special consideration regarding this category is that it is relative to the income of the participant and the alternative ways such money might be spent. These social costs do not fit easily into mathematical formulas. A third category concerns social accounting; this is commonly expressed but rarely added to lists of costs. If X dollars are spent on prevention from a limited fund of health dollars, than at least some portion of X has been siphoned from treatment and rehabilitation funds. Therefore, the argument goes, one cost of a prevention program is not having those funds to spend on ameliorative services. Of course the same argument may be made in consideration of treatment costs as siphoning funds from prevention. This raises values issues in considering priorities and distributions of limited funds, another complication for formulas. Thus a tentative conclusion may be drawn that costs have social meanings that are hard to incorporate into conventional accounting forms--but which may be nevertheless important to persons and groups involved.

Concerning benefits of preventive services (B), the following might be considered. First, benefits to the recipients of the services include--when the program is successful--predicted problems being obviated and the resultant expenses not having to be met, as well as the desired goals attained, resulting in satisfactions to the recipient beyond what would have been expected by chance alone. There is another class of persons who benefit from the recipient's good fortune, who are rarely included in the social accounting of health and welfare services. These are the persons in the recipient's social networks. For example, when time away from a job is averted through preventive actions, then there is less burden on work associates to carry a heavier load to compensate for the recipient's absence. Likewise, when health is promoted, then members of a family benefit from the presence and association with its breadwinners/homemakers.

The most common accounting in preventive activities is savings to society from averted problems--the state doesn't have to allocate scarce resources to these areas--and gains from recipients' contributions. It should be clear that these are complex phenomena on which to assign dollar figures, even though in principle they may be clear. A final category of benefit that never reaches the accountant's books is that to the preventer. There are not only sources of satisfaction and support stemming from successful preventive efforts, there are also important increases in social legitimacy and professional status, necessary ingredients in the competition for health resources.

By dividing the cost numerator by the benefit denominator, one obtains a figure that, in principle, captures a broader range of critical factors than conventional cost-benefit accounting. It should be obvious that assembling figures for such an accounting is very difficult and quite subjective, but it makes reasonable sense in social and psychological accounting--that is, how objective data are to be interpreted. Therefore, it is a useful exercise to attempt to assemble such information, even though the preventer must convey parts of it as opinions and values (Bloom, 1976).

Evaluation of prevention programs is characterized by even more difficulties than other kinds of social program evaluation. While it is difficult enough to show that a particular program has the desired results, given all the constraints against setting up true testing situations in practice where it is sometimes inadvisable to withhold treatment from individuals to arrange for a control group and the constraints against controlling for all the intervening variables so that one is never certain that the outcomes of the programs were actually the results of the activities of the program or some external activities or influences, it is even more unlikely that a prevention program will provide unequivocal outcomes since the "proof" of the effectiveness of the program often rests in showing that something did not occur or did not become a problem.

However, the literature does provide information on how to evaluate prevention programs and does note the value of process evaluation or formative evaluation that takes place as programs develop. Nevertheless, the problems of evaluating prevention programs are what are highlighted in the literature. A great deal of the evaluation literature comes from Bernard Bloom and Martin Bloom writing in the mental health field, and Bernard Bloom has provided the most famous quote, cited again and again in the literature, saying that prevention research is a "nightmare" in which researchers are called on to:

> . . .evaluate the outcome of an undefined program having unspecified objectives on an often vaguely delineated recipient group whose level or variety of pathology is virtually impossible to assess. . . (from Klein and Goldsteon, eds., 1977).
>
> To compound the problem further, some primary prevention programs are small and thus the size of the sample is limited; they are often service projects that are not amenable to experimental, random designs; they often have low budgets, which limits how much can be spent on such nonservice elements as program evaluation; and they usually have no research staff. Yet, evaluation research in primary prevention program is necessary and must be attempted because policymakers need scientific knowledge to make long-term plans, program administrators need the results of research to improve technology, and the field requires information to build knowledge for future programs (Bloom, Primary Prevention).

The literature also provides information on evaluating child abuse and neglect prevention programs specifically.

Problems in Assessing Success

1) Many prevention programs have no research or no adequate research component so success or failure is undocumented.

2) Child abuse is a relatively low incidence variable, i.e., in order to study changes in the rate of occurrence as the result of an intervention, a very large group of people would need to be studied to monitor rates of abuse and neglect in a community before and after a prevention program has been in operation (or compare the rates among program participants with those of a similar group who did not participate).

3) All the information about contributary factors is based on correlational data, i.e., we know that families high on some index of stress are also more likely to abuse or neglect their children than are families low on the same index; but, we do not know that a given factor correlated with maltreatment is in fact a causal factor. Moreover, even if a factor is part of the causal picture we do not know whether altering that factor alone is sufficient to prevent abuse or neglect. However, it seems likely that if we are able to affect a factor correlated with maltreatment, we should be successful in preventing some maltreatment.

Summary

Far too little is known to be able to list those prevention strategies that really do effectively counteract each underlying cause. However, the studies do suggest that much of what has been tried may benefit at least a subgroup of the at risk population. This was true for early and extended contact, for the perinatal support program evaluated by Gray et al, for the Avance Parent Education Program in San Antonio, and for behavior modification programs. On the other hand, the evidence we now have on provision of psychotherapy is not so hopeful.

(Cohen, Gray, Wald, 1984)

From Sundel and Homan, 1979:

An effective child welfare services delivery system should ultimately reduce the active caseload of clients with severe problems (and the recidivism rate), with an accompanying increase in the number of children and families receiving primary preventive and early intervention services. This objective is consistent with the public health model goal of reduction of cases in the tertiary stage. Although few analyses of the costs of services to child welfare cases of varying severity have been conducted, the cost implications of overall reduction of the severity of cases could be important. Over the long run, increased primary preventive activity might reduce the cost of serving cases in an advanced stage of problem development.

With increasing pressures for accountability, program administrators are concerned about measuring program impact. The literature on prevention frequently points to the lack of sound evaluative research in the field, particularly on primary preventive services. This is related to the difficulty of applying the concept of prevention to social problems. Definitive causes of social problems have rarely been established, and primary prevention is targeted to resolve problems before the onset of defined pathology.

Measuring Impact

The conceptualization of child welfare as a comprehensive service system with a preventive component provides a basis for innovative approaches to measuring the impact of services and programs. At the most basic level, it is possible to define services and programs in terms of potential preventive effects for the greatest number of individuals. At the minimum, a program plan should include measures of expected preventive impact in its statements of objectives. For example, a measure of program impact could be the level of citizen awareness of the availability of services to address particular child welfare problems. A recent effort to evaluate a community mental health prevention project indicated the usefulness of this measure in evaluating primary prevention and early intervention activities. Client and citizen satisfaction with services are other useful and often neglected measures of program outcome that could be used in evaluating preventive service programs. The number of self-referrals to prevention programs may be an additional indicator of their value.

The National Association for Mental Health has suggested that all primary preventive activities include the following elements: "A condition which can be observed and recorded in precise terms; an identified population at risk for that condition; a measure of the incidence of the condition in the population; a clearly defined plan of intervention applied to the identified population; and the measurement of incidence following the intervention." Adherence to these premises will provide better indicators for evaluation than currently exist in many programs.

The medical concept of triage, in which service is based on each individual's potential to benefit, has been offered as an approach to accomplishing "the greatest good for the greatest number" in the face of chronically insufficient resources. Although the concept has never been seriously considered in social services, it exemplifies the dilemma of how to set up priorities in problems of children and families. In allocation decisions, important questions include: Is there evidence that the problem can be addressed through preventive services? Are resources available or can they be developed to support prevention efforts? Has cost-effectiveness of alternative approaches been examined? Are community attitudes toward launching prevention efforts positive?

In his article, "A Descriptive Definition of Primary Prevention," Charles T. Adam argues for the value of process as well as outcome evaluation in that it lends itself to decentralized, more democratic activities.

In regard to evaluation Mr. Adams suggests the NPERN Guidelines (French, Kaufman, & Burns, 1979) and the companion evaluation package (Perlman, Kaufman, & Early, 1979).

> This positive focus makes process, outcome, and impact evaluation of prevention activities possible through measurement of positive, identifiable behavior patterns, and not just through long-range reduction in the incidence of identified problems among defined populations (Adam, 1981).

The National Committee for the Prevention of Child Abuse has published a booklet that is very helpful. Written by Ellen Gray and Joan DiLeonardi the publication tells how to evaluate different kinds of prevention programs and explains evaluation methodologies that may be used in different situations. For someone who is not very familiar with evaluation, "Evaluating Child Abuse Prevention Programs" is a good reference with comprehensive though somewhat general information. It also includes sample evaluation tools. It is good, general information; however, more technical knowledge would be necessary to carry out all of the data analysis of an evaluation that was of a large scale.

PROGRAM EVALUATION PROCESS

STAGE	QUESTIONS TO BE ASKED	TYPE OF INFO TO BE GATHERED
1. Needs Assessment	What kinds of programs does the community need and for which groups (be specific)?	Questionnaires and surveys Informal questions of persons in key positions
2. Identification of available resources	Is a program already available or do we have to develop one? What kinds of resources do we need? What resources do we have? Can we pool resources with other groups?	Lists of programs and resources
3. Identification of goals of the program	What do we want to accomplish from the program? How do we know when we have reached our goal?	Statement of goals in specific terms
4. Program Description	Exactly what are we going to do? When are we going to do it? How much will it cost?	Statement of the program description and cost projections
5. Description of the participants	Who did the program serve and how many?	Information on the number of participants and their demographic characteristics, usually obtained by questionnaire
6. Opinions of the participants	How did they like the program? Did they think they learned anything? How can the program be improved?	Questionnaire or interview
7. Changes in knowledge, attitudes, and/or skills	What change did the program make in their knowledge, attitudes, and/or skills?	Usually pre and post test using control group if possible. Can be questionnaire, interview or direct observation
8. Changes in behavior	How did the program change the participants behavior?	Pre and post test with control group. Can be questionnaire or interview, but direct observation is better
9. Consequences of behavior change	How did the behavior change affect other behavior and/or relationships	Self report questionnaire, pre and post test with control group if possible

Martin (1984)

Secondary Prevention:
Prediction of Child Abuse and Neglect/ Screening Tools

Introduction

The following section concerns secondary prevention. It will provide various screening tools that can be used to identify parents at risk of abuse or neglect. As can be seen from the partial list, there is a wealth of screening tools already available. Further, review of an article by Steven McMurtry, Social Work, Spring, 1985, would yield all the available screening measures, and it becomes obvious that there is not much need to develop an original measure for a newly developed program. Also included is information on the issues encountered in secondary prevention and a brief explanation of the differences in secondary and primary prevention.

I. Definition of Secondary Prevention and Research Issues

The important difference between primary and secondary prevention is that primary prevention has as its point of intervention broad segments of society and many or all of its members; whereas, secondary prevention attempts to direct services toward specific individuals or groups identified as having a high potential for experiencing a problem. McMurtry (1985) uses an illustration from public health to point out the contrasts in the two prevention designs:

> Primary prevention is demonstrated by the widespread efforts of the polio vaccination programs of the 1950s and early 1960s that sought to immunize large numbers of people. Secondary prevention is exemplified by programs that try to identify individuals at risk of heart disease (on the basis of weight, eating and drinking habits, and so forth) and then prescribe remedial activities (such as dieting or reduction of smoking) to avert the onset of the disease. Although presumably everyone can benefit from maintaining proper weight and refraining from smoking, it also seems obvious that by no means should everyone be subjected to the sort of regimen required of a high-risk heart disease patient. In this sense, secondary preventive approaches to child maltreatment may offer certain advantages in efficiency of service, particularly since only a comparatively small number of parents are considered likely to maltreat their children.

In his review McMurtry goes on to say that the medical model breaks down considerably when dealing with child abuse and neglect since abuse and neglect is not a clearly defined phenomenon and is often a matter of subjective judgment, and also there is no clear etiology of child maltreatment. Rigorously conducted research in the area is scarcer than suppositions, McMurtry states, and he found a "bewildering" array of causal factors associated with child abuse and neglect. However, his article published in the Spring, 1985, does go on to provide a comprehensive review of the published research on secondary prevention.

A necessary component of secondary prevention programs are measures to identify parents at risk of abusing or neglecting their children.

> As can be seen, these attempts have been important efforts in filling the void of research on predisposing factors and have produced some of the most carefully controlled results available. At the same time, however, they present a variety of dilemmas regarding the possibility of realistic and humane prevention of abuse and neglect.

McMurtry lists four important issues in secondary prevention:

> 1. Is the etiology of the problem such that individually focused screening and treatment are possible?
> 2. Can screening procedures be generalized for broad application?
> 3. Will results of screening instruments be sufficiently accurate to allow ethical prediction?
> 4. Can useful and feasible treatment programs be formulated from the results of such screening?

> The research provides no clear answer to the first question, partly because variables found to be useful discriminators of parents who will later abuse their children often defy combination into conceptually sound orderings (Kotelchuck, 1982; Starr, 1982). Also, each study seems to add new variables to the list, occasionally in conflict with other results. For example, the self-concept of the parent was found to be a useful predictor by some researchers (Schneider, Hoffmeister, and Helfer, 1976; and Disbrow, Doerr, and Caulfield, 1977b), but showed little discriminative ability in other studies (Milner and Wimberley, 1979). Egeland (1979, p. 275) believed his findings "support the notion that there is no particular abusing personality," yet other investigations showed that item clusters and standard scales on the MMPI may be able to distinguish abusers from nonabusers (Paulson et al., 1975b; Paulson, Schwemer, and Bendel, 1976). Still, some variables, such as maternal history, parents' expectations of the child, parental stress and isolation, and special characteristics of the child, were significant predictors in several studies. This and the fact that every study was able to identify at least some useful predictors mitigates against the argument that the etiology of abuse can never be sufficiently elaborated to make screening a feasible procedure.

The Problem of Accuracy

A central concern of the use of screening devices is the problem of accuracy, i.e., the failure to identify some abusive parents (false negatives), and the identification of parents who are actually not abusive as being abusive (false positives). The reality is that many screening devices have been devised, some without much research or testing prior to their use. And, many professionals do not know precisely what is being measured by these tools. However, McMurtry refuses to credit the "worst case" scenario of the problem of false positives, which is that families might carry out a self-fulfilling prophecy if falsely labelled as abusive. What McMurtry does not acknowledge is the social stigma attached to a label such as abusive. He essentially says that children will not be removed from their parents based on a screening device; however, he does suggest, as others have, that an abusive or preabusive label not be used for high risk families, and McMurtry remains optimistic about the future of secondary prevention:

> At present, the literature reflects only a handful of empirical attempts to validate preventive programs, and these tend to report negative or equivocal results. For example, Gray et al. (1977) found that a group of mothers receiving special pediatric attention showed significant change on only one of 13 outcome measures. Gabinet (1979b, p. 811) reported an attempt to provide outreach psychological services aimed at "treatment of the patients' emotional problems. . .based on [a] dynamic personality theory." The follow-up assessment (which utilized descriptive statistics to evaluate scores on a Parental Behavior Scale) suggested that the longer the parents were treated, past a three-month minimum, the greater their improvement. This study is the only one to support the use of personality-oriented interventions, but it is subject to too many methodological weaknesses to be entirely convincing. Finally, Thomasson et al. (1981) used an "ecological model" of child abuse to devise a preventive program for rural parents. Using the Child Abuse Potential Inventory devised by Milner and Wimberley (1980) as a dependent measure, they were able to show a significant improvement in the subjects' scores over time. The difficulty with their results is that changes in presumed potential for abuse may not necessarily portend changes in actual behavior.
>
> As can be surmised, establishing the effectiveness of strategies to prevent child maltreatment remains the principal task for advocates of primary prevention programs and for those associated with developing predictive screening methods. As one author noted, "measuring prevention--the number of times something has not happened--is a difficult, if not impossible, task" (Rosenstein, 1978, p. 524). Yet, in an era of scarce resources, preventive programs can expect to have to present reasonable evidence of their efficacy and to compete for support from the same sources as established treatment services (Miller, 1981; and Sundel and Homan, 1979). Given

> that existing remedial efforts have by no means fully demonstrated their utility, the task facing preventive programs is indeed prodigious. Over the short term, the established treatment-oriented approach seems unlikely to change. For the long term, continued small-scale research efforts to demonstrate the ability of preventive programs to achieve their goals offer the possibility that preventive approaches may achieve wider implementation in the future.

Donald Duquette writing in Chapter 8 of Child Abuse Prediction takes a less complacent view than McMurtry. Duquette is concerned with the legal aspects of screening devices:

> What due process mechanisms will safeguard the personal liberty rights of parents yet allow the screening to take place? What personal liberties are at stake in predictive screening for child abuse or unusual child-rearing practices? Persons scoring as "high risk" may well be reported as suspective abusive parents since, assuming reasonable specificity and sensitivity, the evaluators will have "reasonable cause to suspect child abuse," which is statutory language in most states that sets forth what must be reported. The definition of child abuse in states following the Department of Health and Human Services (HHS) guidelines in their statutes includes "harm or threatened harm" to a child.
>
> Persons identified as high risk will be "offered" services of one kind or another, which they can "voluntarily" accept or reject. The words "offered" and "voluntarily" are in quotes to reflect the fact that the danger of agency or hospital overreaching in response to a questionnaire is present in a way similar to the overreaching discussed above in the context of child protective services. The clients are likely to be poor and among the powerless of society. The clients may be easily cowed by authority figures unless the true extent of authority is made clear. Additionally, persons identified by the screening as high risk bear the burden of being so labeled. The consequences of that labeling are hard to predict.

II. Description of Three Screening Tools

1) Parenting Stress Index: Richard R. Abiden, Institute of Clinical Psychology, Univ. of Virginia, Charlottesville, VA 22907.

   This instrument contains a series of 120 questions designed to assess a parent's level of stress. Most of the questions address interpersonal relationships involving parent and child, and parent and spouse. According to the author, a profile of potential for abuse, as well as other types of dysfunctional parenting, can also be determined.

2) The Michigan Screening Profile of Parenting (MSPP)

This instrument is designed to examine the potential for parent-child interaction problems. It specifically addresses: 1) the special characteristics of the parents; 2) the special characteristics of the child; 3) the crisis that the mother or family are facing at the moment, 4) the support system that is available to the parent. "At this point, the MSPP is a screening questionnaire, the purpose of which is to give a descriptive profile of the individual completing the instrument. It is not a diagnostic instrument and should not be used that way" (Schneider, 1982, p. 157).

3) The Maternal Personality Index (MPI): CAUSES, The Illinois Masonic Medical Center, 836 W. Wellington Avenue, Chicago, IL 60657

This is a predictive tool which has been used extensively to predict those "at risk" for child abuse in order to develop a prevention strategy. CAUSES will allow its use for continued research in the area of prediction for purposes of prevention programming for clients determined "at risk." "This questionnaire is designed to test mothers for attributes of personality associated with maternal behavior thought to adversely influence the development of infants. It may be of value in estimating the risk of atypical development for individual mothers" (Greenburg & Hurley, 1975).

III. Reports of Studies Using Screening Instruments to Identify Families at Risk of Abuse or Neglect

--University of Colorado

Method: This instrument came out of work by Kempe, Helfer, and Hoffmeister. Michigan Screening Profile of Parenting (MSPP). Available from Test Analysis and Development Corporation, 2400 Park Lake Dr., Boulder, CO 80301

Outcome: Results do not indicate specific predictions of child abuse alone, but rather identify potential for parent-child interaction problems, with the Emotional Needs Met (ENM) cluster being the only one to have significant predictive value.

--Denver, Colorado

Method: This is a landmark study which set up a true research situation. Originally developed observations in the delivery room, questionnaire, and interviews.

Outcome: Labor and delivery room observations 75.5% accuracy; questionnaire alone 57.5%; post partum interview 54%; pre-natal interview 54.4%. All four instruments together 79% correct predictions.

--Nashville

Method: A well-known study, often written up. Developed own screening device.

Outcome: Many false positives.

--Tulsa

Method: Developed a family functioning scale on which families were rated over time; using factor analysis developed 5 constructs to describe families.

Outcome: Preliminary; needs more research; valuable for matching families with types of services.

--Dade Co., Florida

Method: Program I: Originally developed measure
Program II: Goal Attainment Scaling

Outcome: Provided proximal information and success, but not distal or long-term success.

--Seattle, Washington

Method: A battery of tests that included interviews, videotaping, psychological testing; discriminant and path analysis were employed.

Outcome: More research on variables needed, though ones tested proved strong.

--Utah

Method: Developed original parenting inventory to identify adolescents as potentially abusive adults.

Outcome: Only measures attitudes; longitudinal research needed.

--Cleveland

Method: A landmark work (Gabinet). Clients are voluntary, but identified by other agencies as potentially abusive; clients from a population of lower class, inner city environment. Parenting Behavior Scale developed to measure progress.

Outcome: Tempered success, but highly regarded for the magnitude of the endeavor.

--Queen Mary Hospital Unit, Dunedin, New Zealand

Method: Another often cited study; a coding system was devised using interviews and questionnaires.

Outcome: The system was rather accurate but needed more refinement; error was usually toward false positives.

--Modena, Italy

Method: Questionnaire by Gray et al. and the scheme used in the "Infant Development Research Project" by Brody.

Outcome: The measures were used as tools to structure intervention, not as predictions of behavior.

--Pittsburgh

Method: Neonatal Perception Inventory (NPI) designed by Dr. Elsie Broussard.

Outcome: The mother's perception of her baby at one or two days old and again at one month was associated with the child's emotional development. Tested at 4½ years and again at 10 years by psychiatrists unaware of the previous findings, those children predicted to be at high risk had more emotional disorder.

--UCLA, California

Method: Minnesota Multiphasic Personality Inventory (MMPI)

Outcome: Attempts to develop scales which can identify parents at risk of abusing their children. Results were varied. There was some success although there were problems with false positives and negatives.

--Tulsa, Oklahoma

Method: Original observation and interviews of mothers in hospital, based on Henry Kempe's work.

Outcome: Have been able to identify "at-risk" children. If parents refuse services, referral is made to child abuse agency and an extremely high percentage become cases.

--North Carolina

Method: Child Abuse Potential Inventory developed by Joel S. Milner and Ronald C. Wimberly after an extensive literature review, preliminary testing, and item analysis that identified 25 discriminators.

Outcome: Factors measured included: distress, rigidity, child with problems, problems from family and others, unhappiness, loneliness, and negative concept of child and of self. The CAP Inventory was compared to the "at-risk" program in Tulsa and was found to have extremely good results in identifying "at-risk" parents. There was a problem of false positives. It was suggested that the hospital's criteria be used in conjunction with the CAP, with the CAP identifying the high priority "at-risk" clients.

--Fresno, California

Method: Index of Suspicion developed by Robert J. Olson at a maternity unit (copy of measure is included).

Outcome: No comprehensive results given.

What can be determined from a review of the literature on prevention is that there is little empirical evidence on which to base decisions about what are the most effective prevention services, a problem that plagues all of social science research. Much of the literature is comprised of defining problems due to the dearth of true research that can provide clear results as to what prevention can accomplish for most of the study results are equivocal or negative or in some way challenged. However, people committed to the idea of prevention continue to forge ahead on devising services that perhaps can prevent child maltreatment, and there are positive outcomes in the field that indicate the work in prevention is not futile or useless. From reading what is rapidly becoming a voluminous body of material, one can find areas in which the body of knowledge regarding child abuse and neglect prevention is making additions that can be helpful in determining what kind of programs are successful. While the information should be used with caution, it can provide needed direction to program planning in the area of prevention.

Causes of Child Abuse and Neglect

Probably most of the research in the area of prevention has focused on finding the causes of abuse/neglect in order to prevent them. The problems are that abuse and neglect have been hard to define, and each new study seems to suggest a new set of causes, or a new configuration as to how they are interrelated. At this time there seem to be no definite answers. However, it is possible to read in the area and find concerns that are mirrored in a particular community, and proceed from there. While none of the "causes," such as those listed in the Prevention Factors Section, have been unequivocally linked to abuse/neglect, there are strong associations in many studies. Also, there are studies that have moved forward in testing various methods for prevention which have had positive results or results that show a need for further refinement of the methods. The following is an overview of studies that have provided guideposts for proceeding with work on the prevention of child abuse/neglect.

Kinds of Programs

I. Perinatal Programs

While no study or no researcher has managed to remain beyond criticism or passed all the tests for stringency in design and ethics (particularly in the area of predictive screening for abuse/neglect), there are some recognized authorities in the field who are admired for their pioneering work, sometimes more so in Europe or Scandinavia than in the United States. The early studies deal almost exclusively with secondary prevention in a perinatal program based at a maternity unit in a hospital. Families are identified as "at risk" of child abuse/neglect using some sort of screening tool or cluster of screening procedures, such as delivery room observations, and pre and post-partum interviews by staff.

--Kempe, Helfer, and Hoffmeister in Colorado

The Michigan Screening Profile of Parenting (MSPP) came out of their work. They also developed a landmark study that is cited as one of the few true research situations in the literature. And, their work is often cited as the basis for further research in the field and as the model for other hospital-based programs with mothers-to-be.

--Gabinet in inner-city Cleveland

This work is noted for the magnitude of the endeavor in that it involved mothers who were in need of many services because of their living situations. The Parenting Behavior Scale was developed to measure success.

--Queen Mary Maternity Hospital in New Zealand

This is another very early study that is often cited in the literature and used as a model for later work.

--Maternity Hospital, Nashville

This study has been written about more times than perhaps any other study. They developed their own screening device, and noted the problem of false positives which lead to much discussion about the effectiveness of screening tools.

--Recent Work

The MMPI is being recognized as an adequate screening tool, particularly certain constructs within the measure. And, work by Milner and Wimberly in North Carolina, the Child Abuse Potential Inventory, was grounded in thorough research to develop the measure, and was then tested in North Carolina and in Tulsa, Oklahoma.

As one can see there are plenty of models with which to work if one is interested in a perinatal program for "at risk" families, and there is not much need to devise an original screening tool as several already exist that have been tested and used extensively.

Also, included in the information regarding perinatal programs is a 1983 overview of federally funded programs sponsored by the National Committee for the Prevention of Child Abuse and Neglect. The study funded eleven 3½ year long projects, four of which were perinatal programs. Two of the programs, Vanderbilt University Medical School's work with low-income mothers and the Rural Family Support Project in Indiana, emphasized bonding by early contact in the delivery room, rooming-in, and in the case of the latter project, father participation. Neither program showed any significant results; however, the mothers in the Indiana program did feel very good about the experience. In the Vanderbilt project it was felt that bonding and attachment is just too variable across populations, depending on too many other factors. These projects gave indications that early attachment and bonding are very complicated phenomena that are difficult to measure in a clinical setting with the prevention of child maltreatment as its focus.

The other two programs did show some positive results. The programs were modelled differently and focused on the volunteer or friendly visitor concept during the post-partum period of a mother's experience. The two projects were the Perinatal Positive Parenting project in Michigan and the Pride-in-Parenthood program in Norfolk, Virginia. The latter showed weak but positive results with measured differences in the mothers' attitudes toward their children and improvement in parenting attitude associated with abuse. The Michigan study did not show any differences in parenting attitude; however, the follow-up study showed increased maternal involvement in child nurturing environments, and most importantly showed more general program benefits for younger mothers than for older mothers. It is important to note that the education dispensed by these programs was in a very supportive atmosphere in a natural helping relationship and confirms that paraprofessionals and volunteers can be very effective.

II. Parent Education

Parenting programs such as P.E.T. and S.T.E.P. have enjoyed popularity for the last decade; however, the published material on such programs consists mainly of program descriptions without any evaluations or studies as to results. The community acceptance and general concensus that the programs are worthwhile has caused them to continue. And, in recent years a new idea has been fostered that they are more effective if they are culturally specific. The programs address unique parenting problems of a particular ethnic or economic subculture in the United States.

NCPCA sponsored four such programs and reported on them in their paper "What Have We Learned About Preventing Child Abuse?" Project C.A.N. Prevent, part of the Avance Parent-Child Education Program in San Antonio, was very successful in its outcome. And, like the perinatal programs with home visitors, had some longer term testing. Originally, the program was designed to aid Hispanic parents of low socioeconomic status. Participants were provided home visitors and child care. Results of the program met the hopes of its planners. Parents were more positive in their child rearing attitudes, more willing and able to negotiate social support for themselves in times of stress, and more hopeful about the future than mothers of a similar background who had not participated in the program.

Unlike the total approach to child rearing of Project C.A.N. Prevent, the Pan-Asian Parent Education project highlighted parenting issues relevant only to members of four Asian communities. Group work was done to talk out issues in a supportive atmosphere. Results included positive feedback, changed attitudes and beliefs concerning some of the most problematic issues, and clearer conceptions by the participants of differences between their culture and "mainstream American culture" with reference to child rearing. However, it was impossible to assess the long term effects of the group work as is the case with the two following projects.

The project Inter-Act was a troupe of actors who presented skits in shopping centers, low-income housing developments, waiting rooms, wherever they could reach parents. Hand-outs were provided and skits included several issues important to parents. The audiences were tested on attitudes targeted by the skits before and after the performances. Results were strongly positive in that attitudes changed significantly for each skit presented.

Another project that focused on attitude change was "Close to Home," which was a series of films that dealt with parenting issues by telling a story of a family. The audiences demonstrated a short-term attitude change but not to a significant degree. What was learned regarding the two creative arts projects was that they stimulate discussion and allow the introduction of highly sensitive material to large numbers of people.

As with any parent education program whether it is formatted as drama or as group work, it is difficult to assess the long term effects of the method. The only program that had some long term testing and comparison to a control group was the San Antonio Project C.A.N. Prevent.

III. Community-Wide Education, Information and Referral Projects

There were three programs benefitting whole communities reported by NCPCA. They were in the rural island community of northwest Washington State, on the Blackfeet Indian Reservation in Browning, Montana, and in the three most impoverished black census tracts in Atlanta, Georgia. All of the programs experienced in different ways two major problems:

> 1) it is widely accepted that "community ownership" of the goals and methodology of community change is an essential component of significant change at the community level; and,
> 2) it is difficult to measure the effectiveness of programs with the community as their target.

Although all three projects did extremely extensive work in training, parent education, establishing new networks of information and referral, developing and disseminating a great deal of material as well as developing services to serve the unique needs of each of the three communities, the effects of the efforts of the projects must remain unclear. In each of the communities child abuse rates continued to climb just as it is increasing nearly everywhere. Without massive and costly studies, these kinds of programs will continue to be undertaken on their face validity. What we have learned is that the demonstration project structure (coupled with the state of the art of evaluation research in prevention) is, for the most part, inadequate to measurably affect the quality of family life for whole communities.

What Prevention Activities Have Accomplished

What has been shown in the body of literature, only a small part of which was highlighted above, is that prevention reduces the severity of abuse cases. Several studies have noted this. While results may not be clear to a statistically significant degree or it cannot be said that activities effectively lowered the incidence of abuse/neglect, it would be very important to individual children and families that services somewhat reduced their problems.

Also, we know that support services through perinatal programs or through home visitor programs can impact on family problems that indicate a risk of abuse. And, finally parenting education activities show positive changes in parents' attitudes at least on a short term basis.

In light of what is known, there are some considerations that should be taken into account when one is assessing the appropriateness of a prevention program or activity for a community.

Community Characteristics

In looking at the community characteristics and the range of prevention activities, the following questions concerning the community might be helpful in deciding what prevention activities should be undertaken.

--What community support exists? How much?

If there has been a great deal of education and public awareness already, one can move to identify specific causes of child maltreatment in a community, to defining the problem and choosing a program which addresses the problem. In other words, a broad definition of child abuse and neglect is accepted or recognized in the community and work can be done to define it more specifically.

However, if such ground work does not exist a more general education and awareness campaign is in order. One would particularly consider activities that would benefit all children, all parents, that is, the general population rather than certain "at risk" groups.

--What kind of community support exists?

From where will the most readily available cooperation from other agencies, professional or community groups come? Who is most knowledgeable about the problem? Teachers? Police? Church leaders? Hospitals? Physicians? Different professionals' ideas about what causes child abuse and neglect mentioned in the Community Section should be considered when working with groups in the community. Each community must develop a program that will suit its needs and the program must be "owned" by community members. A program that is too much dictated by child protective professionals or too authoritarian will have difficulty in establishing goals and meeting them.

--How willing is the community to accept information from other programs and "outside" experts?

If the community seems to be unwilling to rely on expert or other outside sources and insists on reinventing the wheel, a simple start should be made. A technically complicated program that needs support from areas other than the community should not be proposed.

--What professional support is needed?

The resources of the community should be carefully considered. For example, a program which requires individual counseling in an area where such services do not exist or require a great deal of travelling to attain should not be considered. A perinatal program would not be workable in an area where medical staff are not ready to recognize the early signs of risk of abuse or neglect. Films on various kinds of prevention, such as sexual abuse, which require a debriefing or follow-up counseling need to include that component. Sometimes a community's expectations about services are not met due to poor planning.

--Is the community a rural or urban area?

Programs for special groups, such as teen-age mothers, an ethnic minority, or at risk clients are more appropriate for large urban areas. It is more workable to group a larger population into special interest groups. Whereas, in a rural area it is more difficult to put together a group with special characteristics. It might very well be too small to be worthwhile. Programs directed toward the general population would probably be better for a rural area. Also, in a rural area in which there is less anonymity than a big city, there is more of a social stigma attached to the label "at risk" of abuse or neglect. Such labels would best be avoided even in urban areas.

Also, there is some indication that publication of availability of services through the media does not work very well in rural areas. Outreach has to take some other form in rural communities.

--What volunteers will be needed?

Are they available? Will the program generate a continuing supply, such as a friendly visitor program for new mothers who then go on to become home visitors themselves. Is there enough support for the volunteers to prevent burn-out, provide training so that they know what is expected of them?

--What are the costs of the program?

Does the community have the resources to meet the program needs in time, money, people, and commitments to participation?

Summary

These are the questions at hand when attempting to develop a prevention program. Knowledge about the community as well as what has been offered by researchers and workers in the field will enable a community to institute a prevention program that will be helpful to families and particularly the children who depend on such services.

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